HOSPITAL Topics

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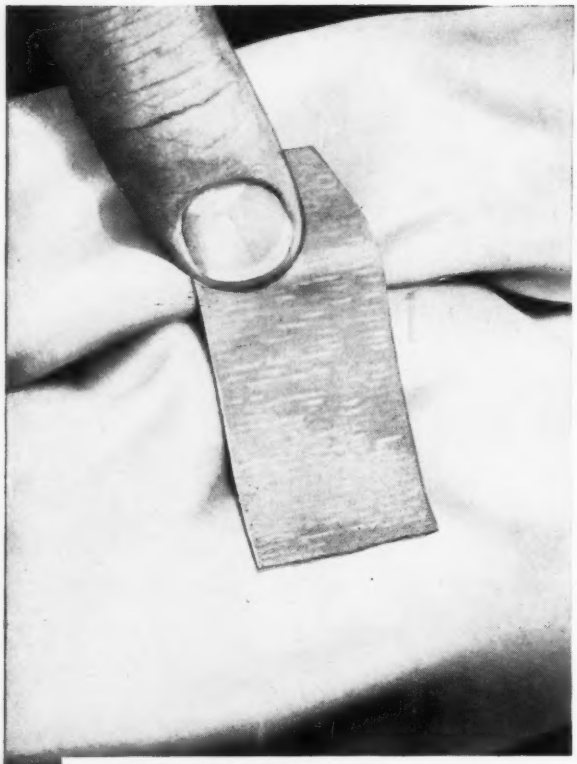

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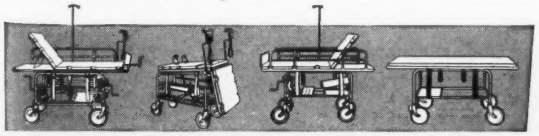

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HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

NOVEMBER 1956, VOL. 34, NO. 11

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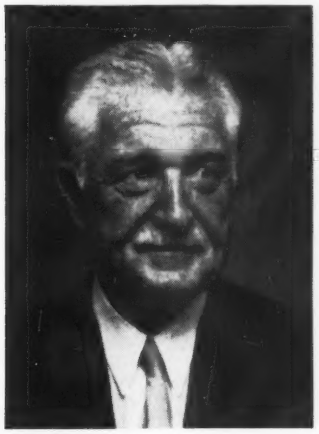


Edgar G. Hayhow, Ph.D., director, East Orange (N.J.) General Hospital, celebrated his 40th anniversary in the hospital field on October 24. He was honored at a trustee dinner at that time.

He was born in New York and educated at New York University where he received his B.S. in business and his M.A. and Ph.D. in social psychology. Later he received a B.S. in humanities from Fordham University.

He took his administrative training at Presbyterian, St. Luke's and Lenox Hill Hospitals, New York. He was assistant superintendent in the hospitals successively from 1916-1924. From 1924 until 1927 he was superintendent of New Rochelle Hospital. In 1930 he became director, Paterson (N.J.) General Hospital and retained it until 1946, when he became director of East Orange General Hospital.

He was first vice-president of the AHA in 1939, and member of the board of trustees from 1940-1943. He was chairman of the joint committee to develop a code of ethics.

He was president of the American College of Hospital Administrators in 1948 and a regent from 1936-1948.

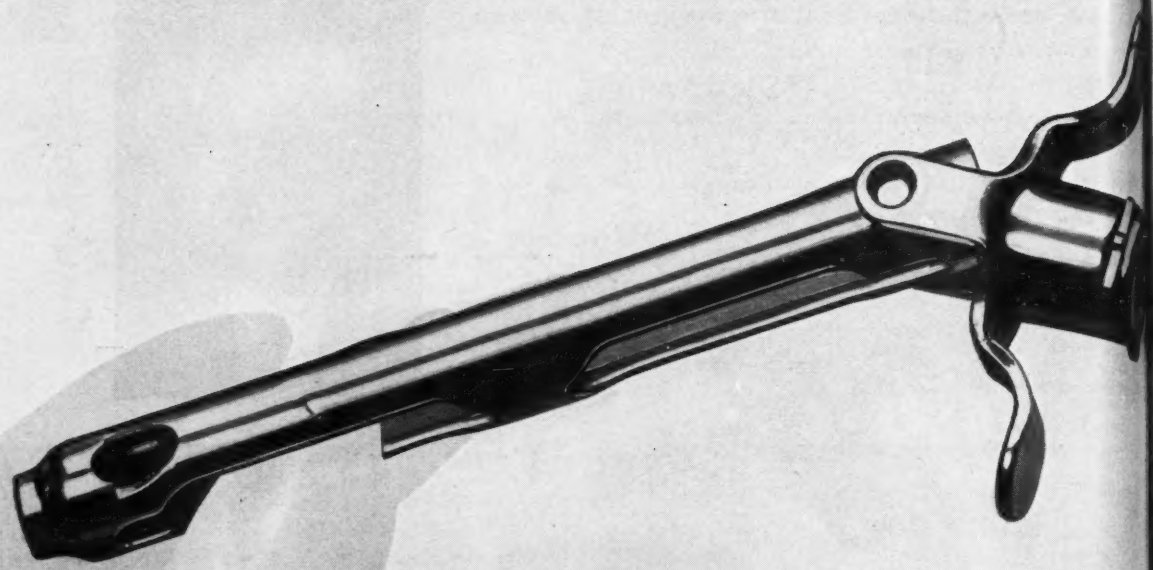
He was chairman of the advisory committee of hospitals and institutions, Mid-Century White House Conference on Children and Youth, in 1950.

Mr. Hayhow, being a single man, stresses his favorite hobby to be traveling.

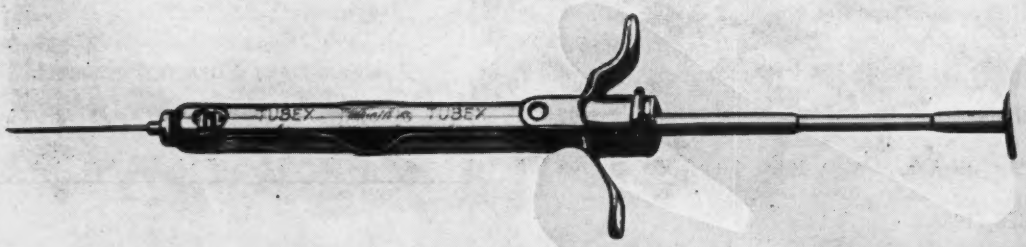
COMING NEXT MONTH

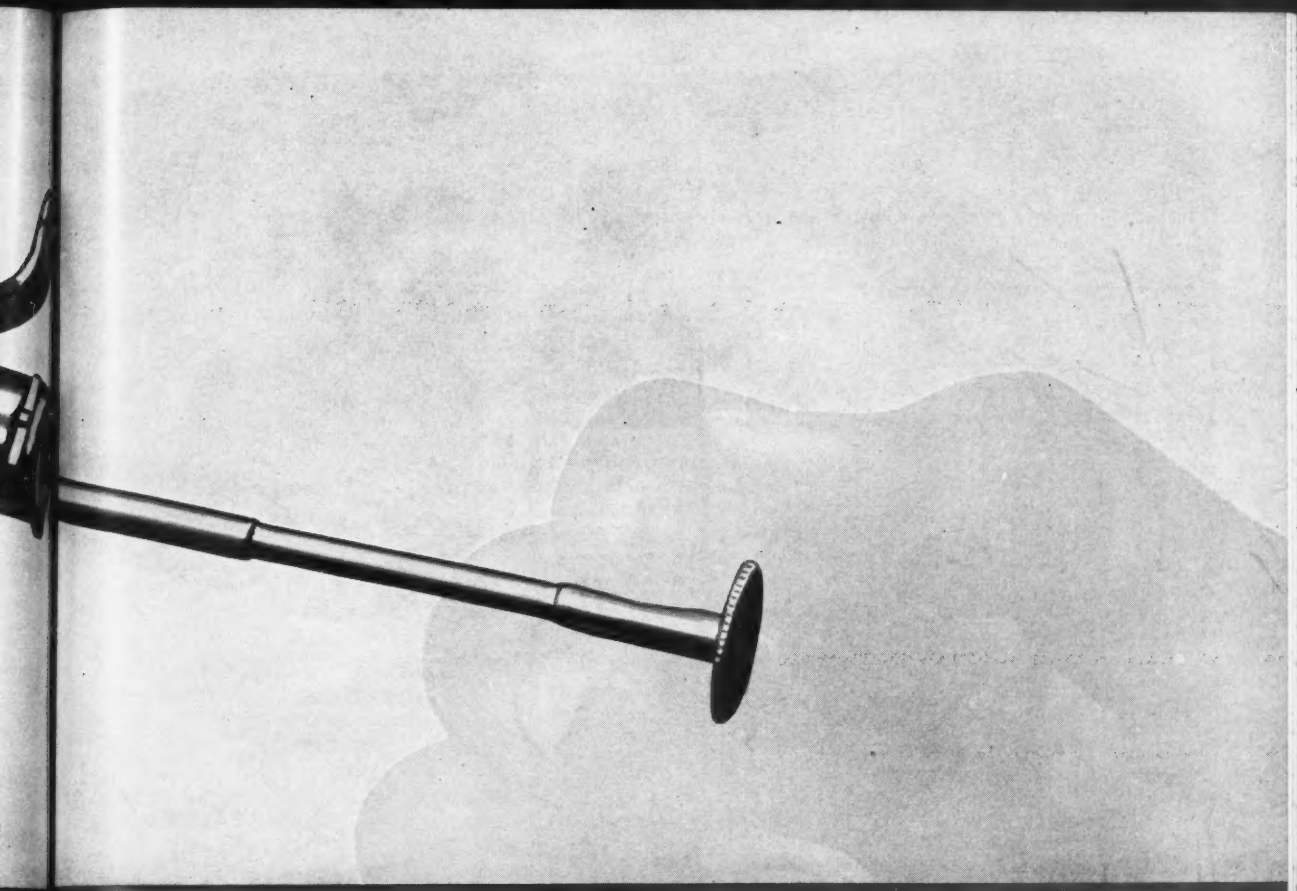
Reports on Indiana Hospital Association and American Dietetic Association

Assignment of Nursing Personnel by Arthur Allen



CLOSED-SYSTEM





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1. Bogash, R.C., and Pisanelli, R.: Hosp. Management **80**:82 (Nov.-Dec.) 1955. 2. Hunter, J.A., et al.: Hosp. Management **81**:82 (March) 1956. 3. Hunter, J.A., et al.: Hosp. Management **81**:80 (April) 1956.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

NOVEMBER 1956
VOL. 34, NO. 11

Scanning the News

Drugs Proved Helpful In Controlling Diabetes

Two recently developed drugs, given orally, have been successful in controlling milder diabetes Rachmiel Levine, M.D., chairman, department of medicine, Michael Reese Hospital, Chicago, told the American Chemical Society's 130th national meeting in Atlantic City recently.

Apparently BZ55 and orinase act upon beta cells in the pancreas, causing them to produce more insulin, Dr. Levine said.

Approximately 20,000 persons are getting the drugs on an investigation basis regulated by the government.

Dr. Levine's report was based on a review of 700 patients in various parts of the country.

Some side effects were revealed. Dr. Levine warned that the substances should be more thoroughly studied for at least another year before they are released for general use.

Golf Tee Plug Used In Heart Operation

A spongy plastic plug—shaped like a golf tee, has been used to close up a tunnel in the heart of Norman Hickey, Richland, Wash.

The tunnel had developed between the base of the aorta, and one of the heart's main chambers. It was corrected in a two-hour operation during which blood flow to the heart was closed off for four and a half minutes. Andrew G. Morrow, M.D., National Heart Institute, Washington, operated.

The surgeon placed one hand inside the heart chamber and placed another incision in the aorta as he guided the plug into place.

Cows and Sheep Particularly Get Very Little Sleep

Certain insects, fish and mammals get along for long periods with little or no sleep, the United Nations Educational, Scientific and Cultural Organization stated.

Dairy farmers and sheep-herders have long suspected that cows and sheep don't sleep. This suspicion has been confirmed by research studies at the National Institute for Research in Dairying, University of Reading in England. Their findings were reported in the British science journal *Nature*.

"Under normal conditions healthy adult cattle and sheep, and probably ruminants in general sleep little if at all," the study found.

Stabled horses sleep an average of seven hours a day.

Geriatric Patients Perk Up With L-Glutavite

Twenty-seven aged men tested became more alert and friendly, and improved mentally when treated with L-glutavite, according to Eli M. Katz, M.D., and Z. Kowaliczko, M.D. Cook County Hospital, Chicago.

The preparation is no cure for mental deterioration. However evidence in favor of L-glutavite is considered good because the patients treated had been static no matter what the surroundings were.

The physicians believe surroundings may have something to do with the improvement observed, although every effort was made not to change the surroundings. Patients afflicted with some incapacitating disease received little benefit from the preparation.

The preparation is a mixture of glutamic acid, niacin, thiamin, riboflavin, ascorbic acid (Vitamin C), ferrous sulphate, calcium and phosphorus. Glutamic acid has been used in recent years to stimulate intelligence in younger persons, though many physicians doubt its efficacy. The two doctors believe that L-glutavite is better than glutamic acid alone.

Good Percentage of Dirt Remains in Lungs, M.D.'s Find

Almost two-thirds of the dust taken in during breathing may stay in the lungs, according to a report before the American Physiological Society made by P. E. Morrow, M.D., D. A. Morken, M.D., L. J. Casarett, M.D., and E. Mehrhof, M.D., University of Rochester School of Medicine and Dentistry.

Human volunteers breathed air containing harmless dust in particles too small to be seen with a microscope. The amount in each respiratory tract was then measured. The frequency of taking breaths, the amount of air moved by a single breath, and the air-flow rate of breathing are related to the quantity of dust deposited, it was found.

High Degree of Specialization Shown in Ragweed

The pesky ragweed, has survived for 170,000,000 years and now represents evolutionary specialization of the highest order, according to Warren H. Wagner, assistant professor of botany, University of Michigan.

Ragweed thrives in the poorest of soils, stands a great deal of abuse, yet functions remarkably well, Dr. Wagner said.

The plant is being studied as part of a hay-fever research project. Researchers hope to tell physicians how and where ragweed forms the pollen-borne substances to which many are allergic, and to tell meterologists how and when this substance is discharged by the plant into the atmosphere on pollen particles.

Surgery Helps Adults With Crossed Eyes

Improvement in appearance alone makes surgery for adult strabismus a success, says Edme Regnier, M.D., Salem, Mass., in the current issue of *GP*.

A psychiatric study of 50 adult squinters was made. Dr. Regnier urged surgery, even if the operation were delayed until adulthood —too late to improve the vision. The improved appearance materially aids the person psychologically the rest of his life.

(Continued on page 113)

American '57

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News Briefs at Press Time

MASUR NEW CLINICAL CENTER HEAD; CRONIN HIS SUCCESSOR AT BMS

Jack Masur, M.D., has been made director of the Clinical Center, National Institutes of Health, Bethesda, and John W. Cronin, M.D., has succeeded Dr. Masur as chief of Public Health Service's Bureau of Medical Services.

Dr. Cronin's former duties as head, Division of Hospital and Medical Facilities, will be taken on by Vane M. Hoge, M.D., who remains associate chief of BMS. At time TOPICS went to press, new assignment had not been announced for outgoing Clinical Center director, D. W. Patrick, M.D.

HAWLEY CHARGES BLUE SHIELD PLANS ENCOURAGE FEESPLITTING

Some Blue Shield plans are encouraging a form of feesplitting, Paul R. Hawley, M.D., charged at American College of Surgeons congress in San Francisco.

Dr. Hawley, ACS executive director, said these plans allow an insurance fee to physician who refers patient to surgeon. He declared this is the same as if the surgeon paid the referring physician out of his own pocket. Any physician who performs a service to the patient should submit his own bill, according to Dr. Hawley, or feesplitting is taking place.

11 HOSPITALS TO REPORT CASES OF DRUG REACTIONS

Eleven governmental and voluntary hospitals will report to Food and Drug Administration cases of unusual or adverse reactions to drugs, in joint study in which collaborators are AMA, AHA, American Association of Medical Record Librarians, and American Society of Hospital Pharmacists.

Hospitals participating are:
St. Joseph's, Providence, R.I.; Medical College of Virginia, Richmond; Lakewood (O.) Hospital; Oakwood, Dearborn, Mich.; Hartford (Conn.) Hospital; Grace, Detroit; Western Pennsylvania, Pittsburgh; Public Health Service, Baltimore, and Walter Reed Army, U.S. Naval, and George Washington University Hospitals, all in Washington, D.C.

SURGICAL INSTRUMENT MAKERS ASK AID AGAINST FOREIGN COMPETITION

Representatives of American manufacturers of surgical instruments held a special conference in mid-October with logistics experts of Defense Department and armed forces to discuss problem of price competition of foreign instrument makers.

Surgical instrument industry in this country is threatened with extinction, the Manufacturers' Surgical Trade Association told armed forces officials, because of the influx of lower-priced foreign products.

Association hopes to get help under provisions of Trade Agreements Act, which authorizes remedial action by the President when Office of Defense Mobilization certifies that volume of certain imports is against national interest.

BEGIN STUDIES ON TRANQUILIZERS AT NIH AND VA HOSPITALS

A psychopharmacology service center has been set up in National Institute of Mental Health to develop and stimulate basic research and testing of tranquilizing drugs. Center, under supervision of Jonathan O. Cole, M.D., will make technical aid and research advisory services available to investigators.

VA will conduct study of clinical effects of tranquilizers in 37 hospitals (30 psychiatric and seven general) over a three-month period. About 1,000 schizophrenic patients will be subjects.

CORRECTION

In TOPICS' report on AHA House of Delegates action on page 19 of the October issue, it was stated in error that the House advocated use of Blue Cross reimbursement formula, even in areas allocated to commercial insurance companies. House-approved resolution was as follows:

"That, in all states where Blue Cross is designated as the Defense Department's administrative agent in the health care program for dependents of uniformed service personnel, member hospitals accept the Blue Cross reimbursement formula in effect in each state or area at the time such hospital services are provided."

The publisher and editors regret the error.

Gordon M. Marshall

Calendar of Meetings

NOVEMBER

1- 2 AHA Institute, Operating Problems for Small Hospitals, Winnipeg, Manitoba

4- 7 American Association of Blood Banks, Netherland Plaza Hotel, Cincinnati, O.

5- 7 American College Obstetrics-Gynecology, Palmer House, Chicago

5- 9 AHA Physical Therapy Institute, Sir Francis Drake Hotel, San Francisco

5- 9 AHA Nursing Service Administration Institute, Sheraton-Gibson Hotel, Cincinnati

6- 7 Colorado Hospital Association Broadmoor Hotel, Colorado Springs

8 IHA Methods Improvement Institute Bradley University, Peoria, Ill.

8- 9 Missouri Hospital Association, Hotel Jefferson, St. Louis

8- 9 Oklahoma Hospital Association Skirvin Hotel, Oklahoma City

9 Minnesota Hospital Association Hotel St. Paul, St. Paul, Minn.

11-14 Assoc. Military Surgeons of the U. S. Statler Hotel, Washington, D. C.

11-15 Southern Medical Association Sheraton-Park Hotel, Washington, D.C.

12-16 AHA Dietary Department Administration Institute, Denver

12-16 American Association of Inhalation Therapists, Park-Sheraton Hotel, New York City

12-16 American Public Health Association Convention Hall, Atlantic City, N. J.

13-15 Institute on Medico-Legal Problems, Sir Francis Drake Hotel, San Francisco

14-15 AHA Institute, Operating Problems for Small Hospitals, Westward Ho Hotel, Phoenix, Ariz.

15 Connecticut Hospital Association, Connecticut Light & Power Co. Auditorium, Berlin

15-16 Kansas Hospital Association Baker Hotel, Hutchinson

15-17 Arizona Hospital Association Westward Ho Hotel, Phoenix

15-20 American Surgical Trade Association 24th Regiment Armory, New York

16-17 Virginia Hospital Association Hotel Roanoke, Roanoke, Va.

27-30 American Medical Association, Clinical Meeting, Civic Auditorium, Seattle

29-30 Florida Hospital Association, Jacksonville

DECEMBER

3- 6 AHA Institute, Obstetrical Nursing Administration, Toronto

6- 7 Illinois Hospital Association Hotel Abraham Lincoln, Springfield, Ill.

8-13 American Academy of Dermatology and Syphilology Palmer House, Chicago

JANUARY

18 South Carolina Hospital Association, Wade Hampton Hotel, Columbia

24-25 Alabama Hospital Association, Whitley Hotel, Montgomery

FEBRUARY

18-20 Association of Operating Room Nurses Conference, Hotel Statler, Los Angeles

27- 1 American Protestant Hospital Association, Palmer House, Chicago

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Arthur Allen

The Nursing Problem

Second in a Series

Making Better Utilization of Available R.N.'s

By Arthur Allen*

The only way the hospital can alleviate the nursing problem is to make more effective utilizaztion of the services of the graduate nurse. The situation cannot be immediately solved by recruiting more persons for the nursing schools. It is doubtful whether a substantially larger number can be trained in present facilities.

Besides, the graduate nurse does not always turn to a hospital upon completion of her course. Attractive openings outside the hospital field offer better working hours and conditions—and of course she may get married.

Thus, the nursing profession has recognized that it must seek other means of meeting this problem. It has been suggested that nursing be functionalized to assign nursing duties to correspond with training and competence of those performing the necessary tasks. Emphasis is placed on training—a large number of practical nurses would be given one year of training. Many "trade" nurses would be trained in two-year programs, while certain supervisory and technical nurses would receive four-year and graduate-college training.

Functional training of nursing personnel raises many questions of principle. The major question, however, is that of urgency. Assuming universal acceptance of such a change in the professional method of educating nursing personnel, how quickly can this change be implemented? With already overtaxing demands due to population increases, the educational system is not apt to change the existing pattern quickly to assume a great and new additional burden. Although there have been proponents for the policy of establishing different levels of nurses to replace or supplement the present graduate nurse, and although foundations have made substantial grants for establishing such training programs since the end of the war, in 1946, nevertheless the acceptance of this concept has been exceedingly limited.

Immediate relief in the problem of the excess of demand for graduate nurse over supply must be found outside the area of basic training and education. A clue to a possible solution is contained in examining the cause of the problem. The problem is not, as is sometimes assumed, that fewer are entering the nursing profession. Each year approximately seven percent of the high-school graduates choose nursing. This figure has remained constant over the last 24 years, with a slight increase during the wartime cadet-nurse program. It is rather due to a greater demand for nurses by the hospitals. In 1932 there were 15 graduate nurses per 100 occupied beds in general hospitals. Today there are 32. The increased demand is attributable to several factors:

1. Shorter day stay of patients, requiring more concentrated nursing care.

2. Extension of the functions of nursing to include such activities as taking blood and giving intravenous medications.

3. Increased use of nursing personnel in specialized activities such as central sterile supply, operating rooms, and outpatient departments.

4. Reduced number of working hours for nurses.

A careful analysis of the performance of graduate nurses has led to the conclusion that while the scope and function of nursing has been extended, little has been done to simplify the operations of nursing, to reduce the nonprofessional work performed by professional nurses, and to assign graduate nurses according to the work-load requirements.

The physical design of the nursing unit can contribute tremendously towards the most efficient utilization of professional nursing personnel. In the plans for the new Rockaway Beach Hospital, a great deal of consideration is being given to this feature of hospital operations. Detailed studies in 15 hospitals have resulted in the conclusion that nursing utilization can be improved by at least 30 percent by:

1. Effective assignment of nursing personnel according to work-load requirements.

2. Organization of the nursing department to provide the most effective supervision and control.

3. Improved personnel practice to reduce turnover.

4. Nursing units of size and design to provide maximum efficiency.

5. Industrial methods of work performance.

Many of the simple procedures introduced into industry by Frederick W. Taylor at the turn of the century have been more or less ignored by hospitals in nursing-unit operations. For example, Taylor recognized that all supplies and services must be brought to the production worker—the person responsible for producing the

(Continued on next page)

*Superintendent, Rockaway Beach (N.Y.) Hospital.

end product. The production worker must never "go to get something." Nursing personnel are the production workers of the hospital. They are most responsible for the hospital's end-product—patient care. Yet we know how many hours they spend in "getting things."

In order to effectively consider the problems involved in assigning nursing personnel, it is desirable to define a proper staffing concept and the standards which may be accepted as applicable.

It is exceedingly difficult to determine whether nursing is "adequate." It is equally difficult to establish that the number of nursing hours in a nursing station is "excessive." The correct amount of nursing care in any nursing station, in terms of the number of nursing hours per patient, is greatly influenced by a number of factors. The effects of these factors vary among hospitals and among units within a hospital. The following quotation is pertinent:

"While adequacy of quantity does not necessarily guarantee adequacy of quality, it is an axiomatic fact that good nursing care cannot be consistently maintained unless there is enough time in which to plan and give that care.

"The premise is sound that the amount of nursing service, professional and nonprofessional, which the institution provides, is a significant index of the quality of nursing service that it gives."[1]

Among the factors which affect nursing time requirements are:

The proportions of graduate, student, and nonprofessional personnel on the staff.

The types of patient accommodations in the unit.

The types of service to which the unit is devoted: i.e., medical, surgical, obstetrical, etc.

The organization and staffing of central service units.

The design and size of nursing units and arrangement of working facilities.

A set of standards was developed in 1947 and published by the National League for Nursing Education. It is used here for comparison. Changes in patient-care practices since 1947, principally the extension of the use of antibiotics and the practice of early ambulation in obstetrical and many surgical cases, affect the patients' nursing-hour requirements.

The standards, reproduced below, show the average number of general nursing hours needed per patient in every 24 hours and the percentage of total nursing hours which should be professional and nonprofessional.

National League for Nursing Standards[2]

Service	Average Number of General Nursing Hours Per Patient	Percent of General Nursing Hours to Be Given by	
		Professional Personnel	Other Personnel
In ward and semiprivate accommodations			
Medical	3.4	65	35
Surgical	3.5	70	30
Mixed (Medical and surgical)	3.4	67	33
Obstetrical			
Postpartum mothers	4.0	65	35
Newborn infants	2.8	77	23
Pediatric—all ages	4.6	80	20
In private accommodations			
Medical and surgical	3.8	76	24

In detailed studies of 18 hospitals in which it was generally agreed that optimum nursing was achieved, the following standard was developed from the average:

Standard Developed from Studies of 18 Hospitals

Service	Average Number of General Nursing Hours per Patient	Percent of General Nursing Hours To be Given by	
		Professional Personnel	Other Personnel
In ward and semiprivate accommodations			
Medical	3.2	51	49
Surgical	3.6	46	54
Mixed (medical and surgical)	3.4	51	49
Obstetrical			
Postpartum mothers	2.7	60	40
Newborn infants	3.0	70	30
Pediatrics	4.1	55	45
Private accommodations	3.3	57	43

Generally speaking, the principal factor in variation from hospital to hospital was the size of the nursing unit. Following is a typical example of the difference in the table of organization between a 30-bed medical unit and a 40-bed unit:

(Continued on page 15)

1. "Hospital Nursing Service Manual," American Hospital Association and National League for Nursing Education. 1950. Page 28.
2. "A Study of Nursing Service in One Children's and Twenty-One General Hospitals," New York: National League for Nursing Education. 1948.

The Hospital Governing Board

First in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

The hospital is one of the most complex of modern enterprises, with many competing elements. The activities of the governing board, the medical and nursing staffs, and the workers in all departments must be coordinated. The financial, business, and professional relations need to be maintained. The standing of the hospital in its relations with the community must be jealously guarded.

All of these objectives can be accomplished only by an organization which assigns definite authority and responsibility to each person. The governing board, by whatever name it may be known, holds supreme authority.

The role of the governing board or "top management," is essentially the same in a hospital as in any organization or business. The board's responsibilities are to define policy in line with the hospital's objectives and to establish methods by which the application of policy can be assured.

Members of the board must be personally familiar with the needs of the community, as well as with the hospital's objectives and its strengths and weaknesses. They must be aware also of the objectives and programs of nearby hospitals.

The more important functions of the board are:

a. To determine and control the policies of the hospital.

b. To provide the necessary equipment and facilities.

c. To establish and maintain the professional standards.

d. To maintain proper balance in the relations between the administrative, professional, and business activities.

e. To provide financial support and control.

f. To maintain good relations with the community.

g. To guard the interests of the patients by selecting qualified persons for all positions in the hospital.

Many court decisions have clearly stated that it is the right and the duty of the board to designate who may practice in the institution, and what professional standards shall be maintained. The board is legally and morally obligated to protect the patient in the hospital from unethical, unskilled, and unscrupulous practitioners. The charter and by-laws should contain a clear statement covering the activities, responsibilities, and limitations of the board. No member should be allowed to make any personal or business profit from his board membership. The board as a whole and each individual member must be careful never to violate the principles of good institutional management. Consideration must always be given to the authority of the administrator and the medical staff in their respective fields. The governing board should build up that authority and work through it.

A large board usually finds it difficult to meet as often as once a month and, normally, has difficulty obtaining a quorum at special meetings. Consequently, an executive committee often must be established to discharge the functions of the board between meetings. When there is an effective executive committee, the entire board need not meet often. The executive committee usually is delegated substantial powers for administration of the institution.

Actually, the size of the board is not of great importance. The important factors are its organization and composition. A small board which has a poor committee structure and members who lack stature in the community will not effectively function. Another board may be very large with effective committees who perform most of the work.

In most instances the size of the board will be dictated by local conditions. Sometimes a hospital will serve a number of small communities, each of which must be represented on the board. In other instances, for fund-raising purposes, or in order to "sell" the hospital to all elements of the community, the board will include a respected member of each major group or "interest" in the community.

It is generally agreed that the medical staff should not be represented on the board. The principal reason is that a medical staff member has a special, personalized interest in the hospital which may conflict with objective policy setting. Other reasons are:

- Other board members may defer to the opinion of the physician, whom they may consider an "expert" in hospital operations.
- It is difficult to find a staff man who can represent all physicians. Other staff men often resent the staff representative. They feel that he is inclined to represent his own interest or those of the department of which he is a member (medicine, surgery, obstetrics etc.), rather than the entire staff.

(Continued on next page)

*Administrator, La Mesa (Calif.) Community Hospital, and chairman, Community Hospital Section, Association of Western Hospitals.

SUGGESTED ORGANIZATION OF GOVERNING BOARD

1. Hospital under 125 beds
2. Average hospital (125 beds)
3. Hospital over 125 beds

GOVERNING BOARD

EXECUTIVE COMMITTEE

- To coordinate the work of other committees.
- To receive committee reports and determine agenda of matters to be brought before full Board.
- To appoint auditors annually.
- To recruit and select administrator.
- To exercise powers and duties of Board when Board is not in session.

(3)

BUILDINGS AND GROUNDS COMMITTEE

- To develop and establish standards of maintenance for existing physical plant and grounds.
- To develop policies concerning the use of contract or direct maintenance, and review and approve contract maintenance agreements.
- To review and approve proposals for additions or alterations to buildings and grounds of the Corporation.
- To serve as a Building Committee during construction and perform such functions as: employing architects, reviewing and awarding bids, and exercising general surveillance over construction.

(3)

PUBLIC RELATIONS COMMITTEE

- To develop and conduct a long-range program to inform the community of the aims, activities, and needs of the Hospital; and to stimulate community interest in the Hospital.
- To develop policies governing contacts and cooperation with local civic and charitable organizations.
- To develop policies governing release of information to press or public.

(2-3)

FINANCE COMMITTEE

- To manage the investments of the Corporation and make specific recommendations to the Board for investments, liquidation, and reinvestment of Corporation funds.
- To approve the use, for current operations, of funds not derived from current income.
- To develop financial policies such as definitions of capital and current accounts, rates of depreciation, and amounts of depreciation and other reserves.
- To study and make recommendations to Board concerning acceptance of gifts and bequests.

(3)

BUDGET COMMITTEE

- To review proposed operating budgets, by department and by program, and submit detailed recommendations concerning their approval to the Board of Directors.
- To approve transfers of funds among departments and among programs within a department, and to approve expenditure of funds in advance of the period for which allotted.
- To review and approve changes in rates or charges, changes in salary ranges for established positions, or other changes substantially affecting operating income and expense.

(2-3)

PROFESSIONAL COMMITTEE

- To review applications, obtain information and recommendations from the medical staff, and make recommendations to the Board concerning appointments, promotions, and retirements of medical staff members.
- To receive and review applications and supporting information and make recommendations to the Board concerning admission of medical staff members to specialized practice.
- To develop policy concerning, and recommend to the Board assignments of, responsibilities to chiefs of services.
- To review Tissue Committee reports, medical records committee reports, and other reports of professional activities, and make such reports and recommendations on staff rules and practices as it deems necessary.

(1-2-3)

JOINT CONFERENCE COMMITTEE

- To serve as a medium of liaison for the Board, the medical staff, and the administration.
- To develop and conduct an active program for bringing about a common understanding of Hospital problems on the part of Board administration and staff.
- To coordinate approaches to solutions of common problems.
- To hear and rule on, or make recommendations to the Board concerning, specific disputes between the medical staff and management.

ADMINISTRATOR

HOSPITAL GOVERNING BOARD

(Continued from page 13)

Current practice is to permit medical staff members on the governing board.

To function effectively, the board must have committees which can cope with board problems of policy. When many committees are concerned with limited areas, the following generally results:

- Subdivision into small segments does not give any committee a comprehensive understanding of a general area.
- Important problems may fall in between narrowly defined committee functions, and hence not receive appropriate consideration.
- Energies of board members are dissipated when members are assigned to a number of different committees.

A board organization is shown on the opposite page. This structure provides for both a professional committee and a joint conference committee. The professional committee should assist the board in discharging its responsibilities to the community for maintaining a qualified medical staff and high standards of medical care. The reason for the existence of a professional committee is to place the board ultimately at a level above, and responsible for, the activities of the medical staff.

The joint conference committee has as its principal functions liaison and communications between the medical staff, the administrative elements of the hospital, and the board. It should concern itself with the study and solution of problems arising from conflicts between the administrative and medical areas of the hospital.

The joint conference committee usually is composed of three members of the governing board and three members of the medical staff. The latter are selected by the executive committee of the staff. The administrator is commonly named as an ex-officio member, with the president of the board as chairman of the committee.

Ideally, every hospital, regardless of size, should have all the committees shown on the chart. From a practical standpoint, however, it is not likely that hospitals of 125 beds and under would have some of them. Therefore, numbers have been used to designate which committees are essential to all hospitals and which ones usually are found only in hospitals of more than 125 beds.

NURSING PROBLEM

(Continued from page 12)

TYPICAL TABLE OF ORGANIZATION

30 and 40-Bed Medical Nursing Units

Professional	30-Bed Unit	40-Bed Unit
Head nurse	1	1
Day Shift	3	3
Afternoon Shift	2	2
Night Shift	1	1
Nonprofessional (Female)		
Day Shift	2	3
Afternoon Shift	1	1
Night Shift	1	1
Nonprofessional (Male)		
Day Shift	1	1
Afternoon Shift	½	1
Night	1	1

The ratio of nursing hours per bed in the above is 3.5 for the 30-bed unit, and 2.9 for the 40-bed unit.

The surgical units were staffed similarly to the medical units, except that there was usually one graduate nurse more per unit in the morning, and a greater number of orderlies around the clock.

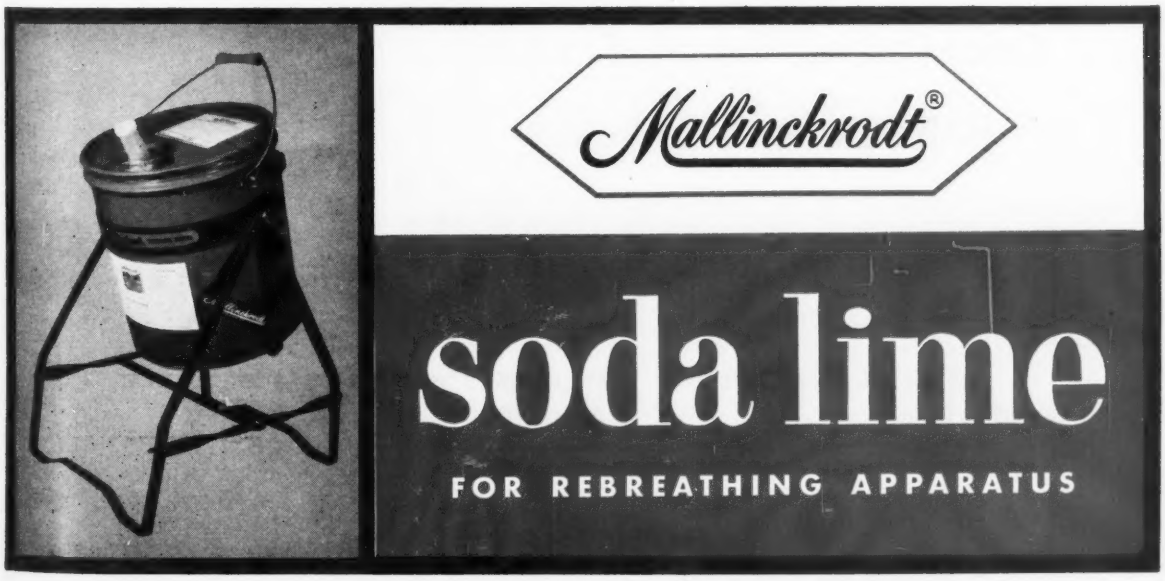
There appears to be a tendency to increase nursing for newborn infants. The usual pattern is one graduate in the morning shift and one in the afternoon shift, with a graduate sharing two nurseries at night. Usually an attendant was assigned to each nursery in the morning. This pattern was generally true, whether the nursery had 10, or 12 bassinets.

The relatively high ratio for pediatrics was due to two major factors:

(1) The extreme variation in occupancy in these units, and

(2) The relatively small units. Even in hospitals from 200 to 300 beds, the units varied from 16 to 24 cribs and bassinets. In the units with 16 cribs, the ratio was higher than the average of 4.5. In the units with 24, the ratio was lower than the average —3.7.

The series by Mr. Allen will continue next month, with additional material on the assignment of nursing personnel.—THE EDITORS.



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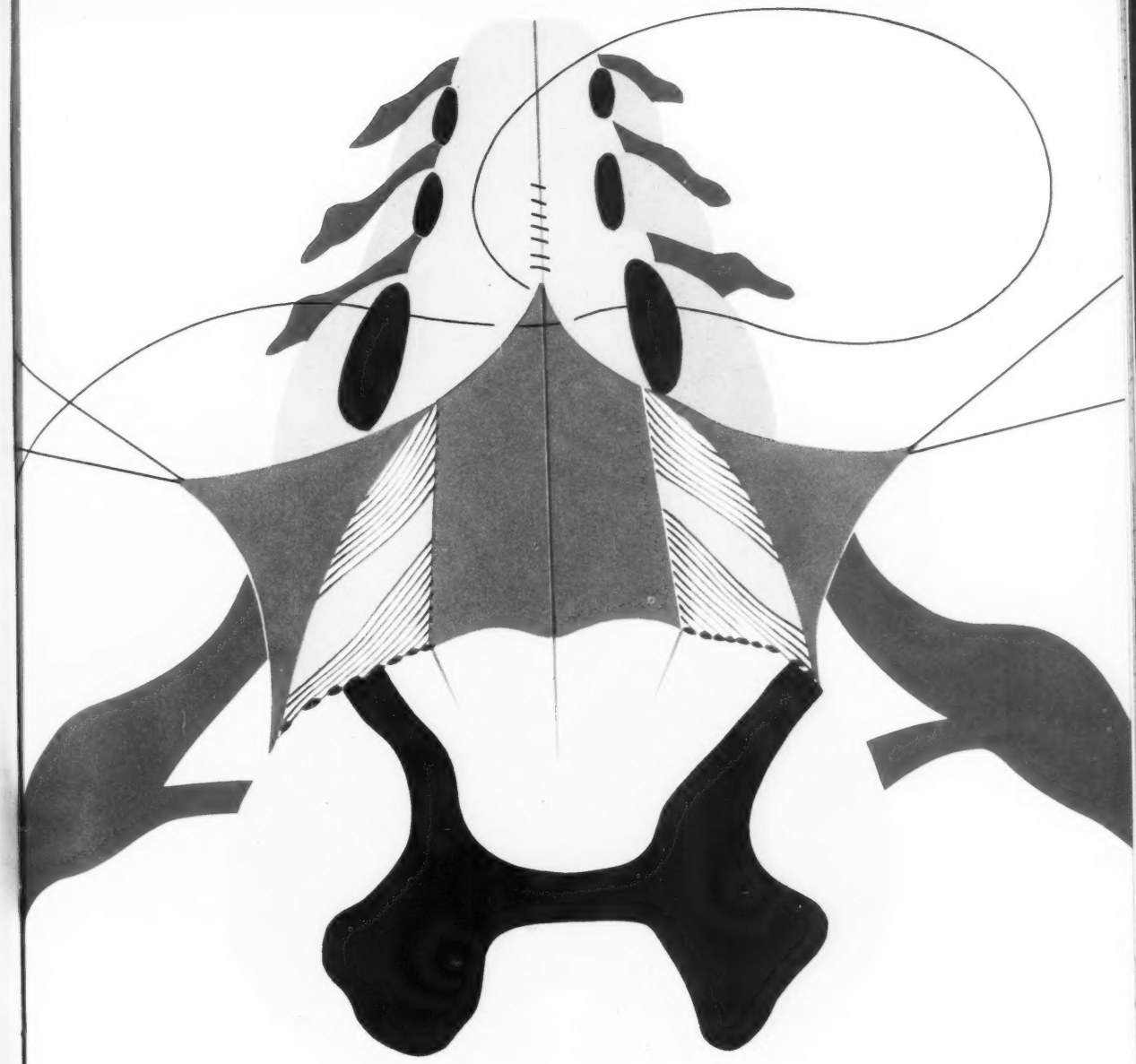

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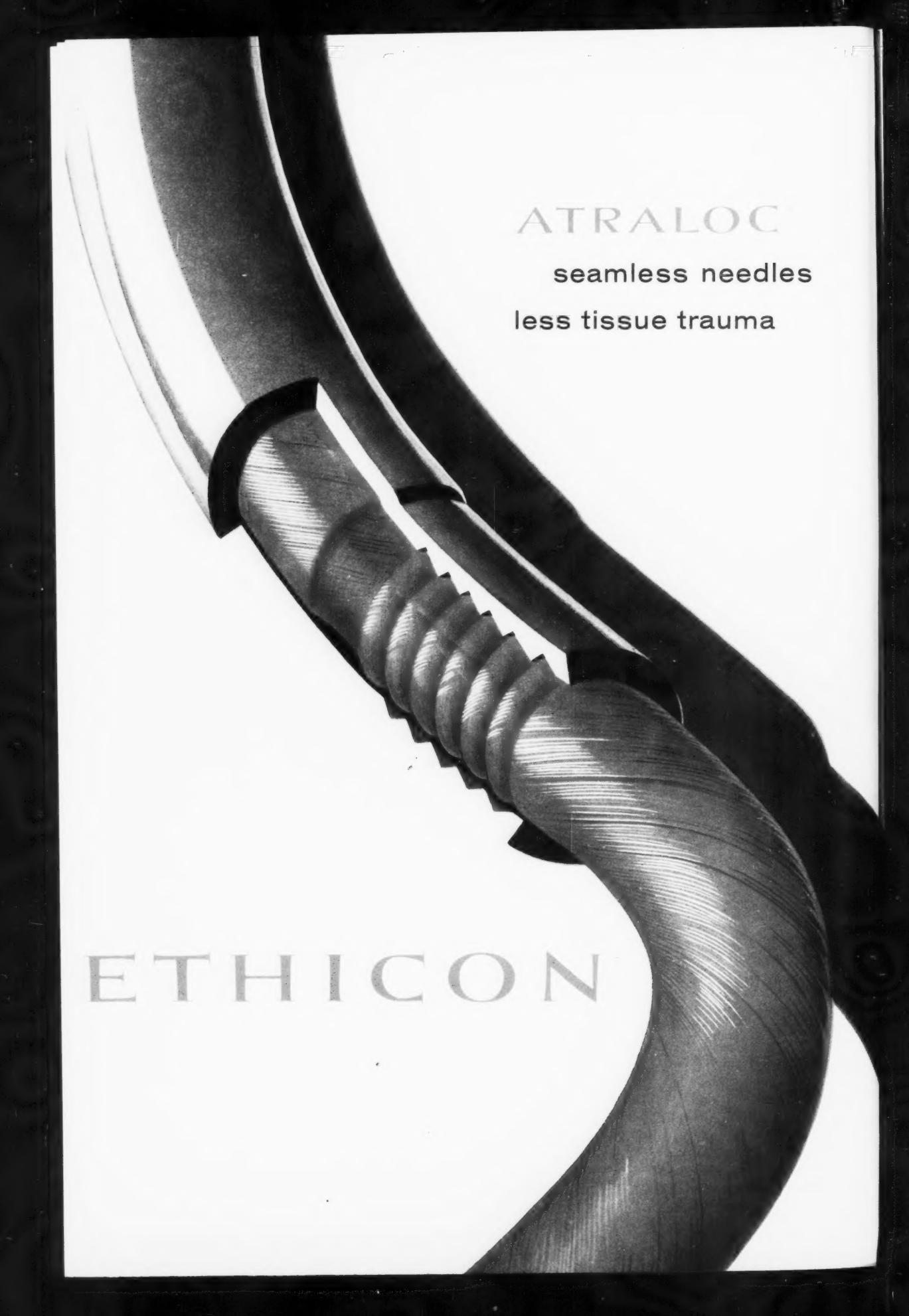
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Hill-Burton: Evaluation On 10th Anniversary

. . . and predictions for the future

Senator Lister Hill, a co-founder of the Hill-Burton program, and others who have had close relationships with the program since its inception, have been asked by HOSPITAL TOPICS to present this 10th anniversary appraisal.

A key figure in the success of the program has been John W. Cronin, M.D. (r.), who, as chief, Division of Hospital and Medical Facilities, U.S. Public Health Service, has been directly concerned with federal administration of Hill-Burton. Dr. Cronin has just been promoted to chief of the PHS Bureau of Medical Services.

Dr. Cronin

THE autumn of 1956 marks the 10th anniversary of the Hospital Survey Planning and Construction Act, commonly known as the Hill-Burton program. Its record is impressive. Perhaps no other program has ever received the universal acceptance and wholehearted national acclaim that has been accorded this federal assistance to hospitals. At no other time in history have the federal, state and voluntary forces worked so effectively together.

The illustrations presented here—through the cooperation of the U.S. Public Health Service—tell the Hill-Burton story.

When the Hill-Burton Act was passed in 1946 there were millions of people living in areas without hospitals. (See Exhibit 1.) In 10 years the majority of areas previously without hospitals built facilities—most of them under the Hill-Burton program. (See Exhibit 2.)

Contrary to what some of the critics have said, Hill-Burton is a balanced program. It not only has built hospitals in rural areas but also has aided many of the medical schools and teaching hospitals, so that there would be adequate practitioners and specialists to staff the rural community hospitals. (See Exhibit 3.)

Exhibit 1

In 1946, ten million people lived in areas with no acceptable *general hospital beds.*

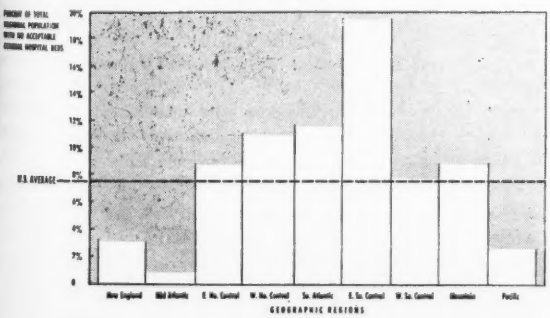
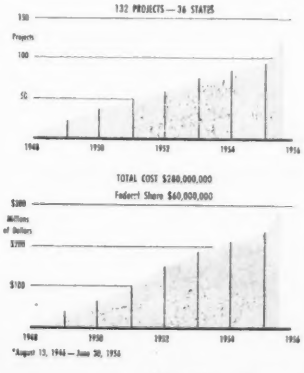


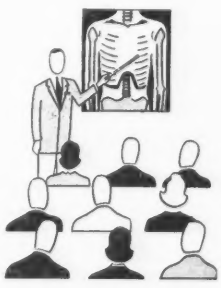
Exhibit 2

Areas without acceptable general hospital beds declined sharply, 1946-1956.

Exhibit 3

Hill-Burton aid to medical school and teaching hospitals has helped expand training facilities for many health professions.*





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Because hospitals age and become obsolete, the gain in acceptable beds has not kept stride with hospital construction volume. 1948-1955.

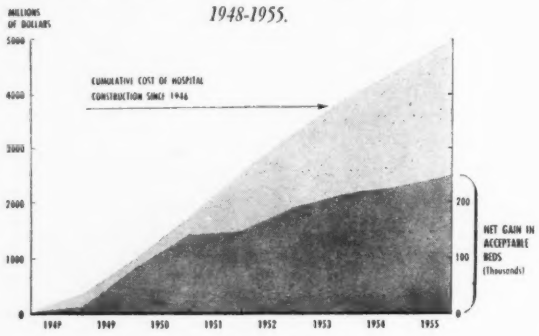

Exhibit 4

Because of population increases, the States must continually raise estimates of total hospital beds needed.

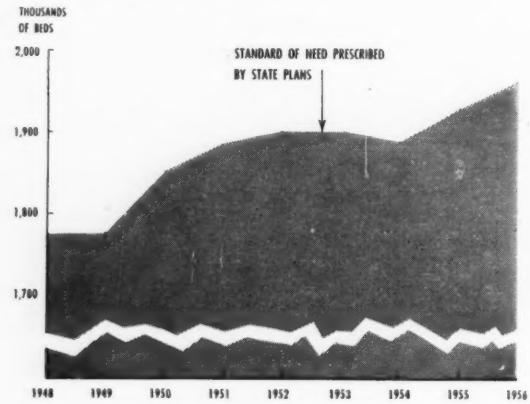

Exhibit 5

In 10 years much has been done—but the job is not completed. There are two great factors which continually increase the hospital bed need in the United States—obsolescence of present facilities and the increasing population. (See Exhibits 4 and 5.)

In 1954 the Hill-Burton Act was amended to provide special funds for certain types of facilities. Exhibit 6 shows the distribution of projects and beds approved since 1954.

The total contribution of Hill-Burton to patient care in the United States may be summarized by Exhibit 7.

Since 1954, nine types of medical facilities have been eligible for Hill-Burton aid.

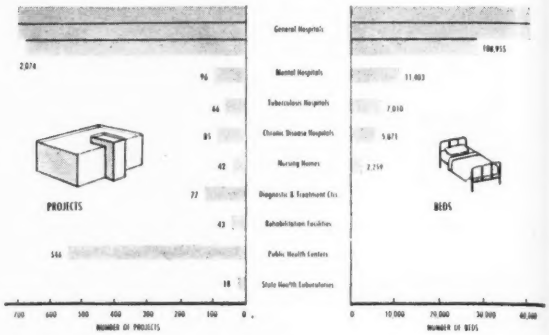

Exhibit 6

$2.5 Billion in Hill-Burton construction projects have been approved since the program began, Aug. 13, 1946—June 30, 1956.

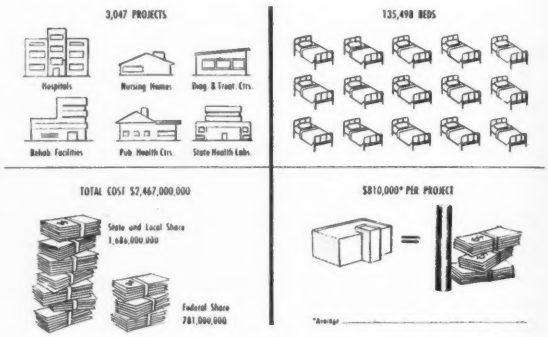

Exhibit 7

quence. Yet this is certainly the case with the Hill-Burton Hospital Survey and Construction Program.

Naturally, there has been criticism, but most of it has been constructive, and much has resulted in changes in the program—for example, the amendments of 1954, which broadened the law to include funds specifically for rehabilitation centers, nursing homes, chronic disease hospitals, and diagnostic and treatment centers.

There are many reasons for the equability which has graced the life of the Hill-Burton program. But, as I look back, it seems to me that among the major contributing factors were the wisdom and understanding with which the original legislation was formulated.

The pattern of the program began to take shape in the work of the Commission on Hospital Care, under the direction of the late Arthur C. Bachmeyer, M.D. From the findings of the commission and other groups, various members of Congress began to hammer out the legislation in 1944 and 1945.

Through the statesmanship of Senators Lister Hill, Harold H. Burton, and the late Robert A. Taft, provisions were incorporated to meet the needs and requirements of the committee, the states, and the federal government. The inherent rights of the states and their communities were clearly protected.

Program Almost Without Opposition

By Vane M. Hoge, M.D.
Assistant Surgeon General
U.S. Public Health Service

• It is a unique experience in government annals to look back over a program of 10 years' duration and find scarcely any serious opposition or criticism, especially if the program has social impact of major conse-

Funds are made available on the basis of comparative need. The quality of construction is maintained by architectural and engineering standards, which, while advanced in concept, were made flexible in this application.

Because of the soundness of the original legislation, together with the equal soundness of administration at every level, the program stands today as a singular example of the cooperation possible between the federal government and the people.

From this union of effort have come new strength and purpose. As each has added his own knowledge and work, all of us began to find new insight into the potential of the facilities we help to build. Today, we look forward to the time when the hospital will become truly the health center of the community—when the people and their physicians will look to the hospital and its supplementary facilities as the matrix of individual and family health.

Hill-Burton Credited with Raising Building Standards

By Donald Ritchie, Partner
James H. Ritchie and Associates, Boston

Before the passage of the Hill-Burton Act, there were only a few architects who were sufficently concerned with hospital design to specialize in this field and to give the problems of hospital planning the necessary thought and study. The result was that many hospitals were inefficiently planned and varied greatly in the quality of construction.

The planning and construction requirements of the Hill-Burton Act have set a minimum standard that has developed well-planned and well-built hospitals and has applied to almost all hospital construction, whether it has received H-B assistance or not.

The program has not done the architect's thinking for him, but it has stimulated him to a more serious consideration of the problems of integration of departments and flow of supplies and patients within the structure.

It has also set a standard of construction and use of materials that is not luxurious but is in keeping with low maintenance costs and functional use.

The results of the program can be seen in better-planned, better-built hospitals which will meet today's needs and are also flexible to accommodate future changes in medical technics.

Hill-Burton Stimulates Community Action

By Arthur Allen, Administrator
Rockaway Beach, (N.Y.) Hospital

• In just a few months, ground will be broken for Rockaway Beach Hospital—a 180-bed hospital which will replace an obsolete, non-fire-resistant facility.

For many years there was common agreement on the need for improved and enlarged hospital facilities for a rapidly growing community. There was a great deal of talk, but the money needed was not forthcoming. Then the Hill-Burton grant of $850,000 was announced. What a shot in the arm that proved to be!

The grant was offered on condition that the hospital have available two-thirds of the cost of construction. Our treasury was sadly empty, and prospects for an immediate successful building fund drive had previously been considered not too good. But now we were presented with a goal that was tangible, close, and most desirable —certainly worth fighting for.

According to the terms of the grant, one-half of the sum required of us could be produced in cash or its equivalent, while the other half would be acceptable in the form of a mortgage on the new building. Eventually, after heroic efforts by the board, when things were beginning to look hopeless and we feared that we might have to forfeit the grant, we managed to secure a mortgage commitment from a nearby bank.

This success was an additional stimulus to the fulfillment of the balance of the terms of the grant—$850,000 to be raised in cash or its equivalent. The board accomplished this seemingly impossible task in record time. We have a staunch group of loyal supporters, who merely needed concrete evidence that a new hospital building was actually possible. In short order we had oversubscribed the set quota.

The grant thus served a twofold purpose—it provided a third of the funds and stimulated the community to maximum efforts.

Impact of Hill-Burton On Our Community

By Robert W. Beckwith, Administrator
Community Bailey Hospital
Chamberlain, S. D.

• We have watched the progress of the Hill-Burton program from the conception of the act in Washington, through the counsel and leadership furnished by the Division of Hospital Facilities of the State Department of Health, and finally to its application on the local level.

When our hospital was bursting at its seams with 100 and 110 percent occupancy, we were forced into new planning—planning far different from the original efforts to provide so many beds per thousand of population. This time we found our greatest need in the division of services. A division of services into medical, surgical, obstetrical, and pediatric was made possible with the aid of Hill-Burton funds.

Then, when attention was focused on the need for facilities for care of the aged, we made another application for matching funds for construction of an addition to provide such facilities. We are now in the process of completing this addition, which will add untold benefits to the community health picture and the over-all services of this hospital.

Without adequate facilities and personnel in our 40-bed hospital, it would be much more difficult to interest new doctors in rural areas such as ours.

Diversification of our essentially farm and tourist economy may depend on facilities the community makes available as an inducement to industry. Among the resources industrialists must look at nowadays are the benefits the community can offer in terms of school, health, and recreation facilities. Perhaps our Hill-Burton hospital can be a factor in the diversification essential for the welfare of all the community.

(Continued on next page)

A new hospital, with improved procedures and technics, may well act as a stimulus to encourage community improvements in water, sewage, street, and other services. After all, a new suit points up the need for replacing an old pair of shoes.

Senator Hill Looks to Future Of Hill-Burton Program

By Lister Hill
United States Senator from Alabama

• During the 10 years of the Hill-Burton program, 114,000 new hospital beds have been added to the nation's total, but most recent estimates indicate that the deficit is still very great. Over 800,000 additional beds will be required to meet the country's total peacetime needs.

Unmet hospital construction needs vary among the states, but it is currently estimated that over 24 million people have one-half or less of their minimal bed needs satisfied in the general hospital category alone.

The net gain in hospital beds has been minor because of population growth, which alone requires some 30,000 additional beds annually, the physical and functional obsolescence of existing hospital plants, and the closing down of antiquated hospital facilities.

According to estimates, more than 50 percent of the nation's hospitals are over 50 years old, the average life-expectancy of a hospital building. These older hospitals and many others were built without regard for modern rapid development of new medical technics and are subject to functional obsolescence in these days of radioactive isotopes, multimillion-volt x-ray therapy, early ambulation, and current diagnostic procedures.

There is still a great unmet need for the construction of public health centers. Such facilities are essential to a complete medical service in a community. They emphasize the preventive aspects of modern medicine. In rural communities and remote areas, where it is financially impossible to maintain a general hospital, the construction of diagnostic or diagnostic and treatment centers brings essential health services to the people.

There is also a pressing need under the Hill-Burton program for expanded rehabilitation facilities, and an almost unlimited need for nursing home facilities. Today only one-eighth of the estimated needs throughout the nation are being met in the chronic disease category. The requirement for adequate mental facilities is only now being precisely estimated, but we know that the need is overwhelming.

There is ample evidence of the great need for a continuation of the Hill-Burton program and an increase in the allocation of funds for this program.

Future of Program in Providing Facilities for Nursing Education

By Rep. Frances P. Bolton
Congresswoman from Ohio

• I am glad to have this opportunity to comment on the important contribution which the Hill-Burton Act has made during the past 10 years in providing more and better hospital facilities for the care of our sick.

As a member of Congress, my concern has long been to assure adequate patient care. This means not only sufficient hospital beds but an increasing number of doctors, nurses, medical technicians, and other related personnel to care for the increasing number of people now taking advantage of hospital and other health facilities.

Of deep concern to the country has been the growing shortage of nursing personnel. It is good to know, therefore, that of the 3,047 projects provided since the inception of the Hill-Burton program, approximately 160 were for nurses' residences and training school facilities. Such accommodations are particularly necessary if we are to give the best possible training to the many young women who wish to enter the nursing profession.

The 84th Congress, just closed, took other definite steps to relieve the nurse shortage when it passed the Health Amendments Act of 1956. This act provides, among other things, traineeship grants to prepare graduate nurses for teaching, administrative, and supervisory responsibilities, and earmarks monies to assist the states in training practical nurses under the Vocational Education Act. The Health Admendments Act also extended the Hill-Burton program for an additional two years.

The new facilities to be constructed will, without doubt, play a very important part in providing more educational oppportunities for nurses and other health personnel.

Role of State Hospital Construction Agency

By John J. Bourke, M.D., Executive Director
New York State Joint Hospital Survey
and Planning Commission

• State agencies administering the Hill-Burton program have an enviable opportunity and indisputable responsibility to provide leadership to the individuals and organizations concerned with hospitals. Hence, they should be flexible of thought; exercise vision based on documented trends; assess the effects of changing medical practices on hospital and related services, and relate architectural planning to the envisaged hospital program and the characteristics of the local community.

These agencies are entrusted with a stewardship—to the patient, his family and physician, the hospital, the community, the taxpayer, and the contributor. Consequently, they should foster projects which are "right" for the respective localities; adequate and well-built but not overly costly; and dedicated to caring for patients when they need inpatient care, yet discharging them as soon as they can be served adequately on an ambulatory basis, at home, or in a proper nursing home.

Consultation services of a state agency to a community and its hospital should be initiated early in the planning stage of a project, *preferably* upon request. They should encompass consideration of the community's sociology and economy; capacity to operate a hospital; pattern of medical care; potentiality for providing medical care of high quality; means for ensuring a continuity of care of the patient on the job, at home, and in medical care institutions.

A consultant should serve through all stages of a project, and his suggestions should be conveyed patiently and constructively in successive conferences with the sponsoring groups.

Effective medical care comprises the prevention of disease, early and accurate diagnosis of illness, prompt

treatment, maximum possible rehabilitation of the disabled, and a return to self-care and productivity.

Since each step toward these goals materially varies the type and volume of care needed, the community hospital must be adaptable. Yet not every hospital should or can provide a full range of services. Thus, radiation therapy seems unwarranted in a 50-bed hospital which could secure this service through a working arrangement with a nearby larger facility or medical teaching center.

The local general hospital of today may be the health center of tomorrow, a partner of the other organizations and individuals devoted to the maintenance of the community's health. If it is to fulfill its proper role in this orbit, the facilities, policies, and program of each hospital must be flexible and practical and reflect good medical practices, yet be consistent with the economy, mores, and hopes of the community it serves.

Future Trends of Program in Georgia

By R. C. Williams, M.D., Director
Division of Hospital Services
Georgia Department of Health

• The hospital construction program has been well accepted in Georgia, and a great deal of progress has been made in providing more adequate medical care facilities. There is evidence that the program will continue to receive the support of state and local leaders based on the backlog of applications now pending. The rate of new construction in Georgia has been slightly less than that needed to keep up with population increases and rate of obsolescence of existing facilities.

In the early years of the hospital construction program, emphasis was given to providing a better distribution of medical services in the state. Rural hospital needs in Georgia, except for a few areas, will probably be met within a year or two. More construction will take place in the larger cities than in the past. Most of this construction will be expensive projects that will include remodeling and expansion of existing general hospitals.

As facilities for short-term acute illnesses become more adequate in the state, increased interest on the part of general hospitals, especially larger hospitals, will be directed to provisions for a wider variety of hospital services. This will result in more emphasis on the various categories included in the Medical Facilities Act of 1954, such as diagnostic and outpatient treatment facilities, rehabilitation centers, chronic disease units, and nursing homes providing care for long-term patients.

In addition, there are indications that more emphasis will be directed towards improved and enlarged facilities for schools of nursing and other hospital training programs. The number of construction projects in Georgia will probably decrease, but the demand in terms of money will increase because:

(1) The projects will be larger and will include expensive remodeling of existing structures.

(2) Construction costs will continue to increase, thereby decreasing effective construction. Furthermore, recent enactment of Public Law #569 (84th Congress), providing for the care of military personnel and dependents in civilian hospitals, may result in unexpected demands for hospital construction in defense areas.

Should Hill-Burton Be Extended?

By Martha O'Malley, M.D., Director
Division of Hospital and Institutional Services
Indiana State Board of Health

• We will not give a specific answer to this question—except to say that the provisions implied in the Hill-Burton program are needed as much or more now than when the act was passed 10 years ago.

The requirements on survey and planning will undoubtedly be recognized in the future as having a greater contribution to the hospital and health field than the actual money made available for construction. This is true even though up to now the survey and planning have not been refined to the degree necessary. However, the concept of survey and planning is now commonly held not only by the leaders in the field but by the people in communities who are faced with the necessity of constructing new and additional hospital facilities.

The guide available to communities through the state hospital, medical facilities, and health center plan developed in the states under the Hill-Burton program has been accepted by communities as an indication of their need. In certain instances, they have had additional appraisal and have sought the aid of private consultants.

This action on the part of responsible people shows the realization that the requirements of the community must be determined before facilities are constructed. Therefore, whether or not the Hill-Burton bill is extended, the availability of this service to the people from public and private sources is a proper health service to the communities.

The fact that the public agencies have been involved has not deterred people from seeking help from private resources. On the contrary, requests for such help have increased tremendously, with the public agencies working cooperatively with private consultants thus engaged.

However, to do the job that needs to be done, there is need for far greater refinement of community measures to be more selective in the type, the relationship and size of facilities needed to properly serve the people of any given community. In fact, there must be a facing of what the hospital truly is of itself and in relationship to other community resources.

In the public mind, the hospital has almost become a panacea for all ills and hurts of life. Turning to the hospital with such complete expectation, although good on one hand, is very bad on the other—because people are so often disappointed in that they expect help or services from the hospital that it is not able to perform and, at times, should not try to perform.

Hospital people must honestly and openly spell out their role. Following this, they must, first, develop their hospital program so that they truly fulfill their role and, secondly, make this information generally available to persons served by the hospital and to the entire community.

The state in which hospitals politely say, "We are an acute general hospital," gearing services accordingly, despite the fact that 30 to 50 percent of their patients are persons with chronic illnesses, cannot long be tol-

(Continued on next page)

erated. However, there is nothing in the present gross community measures to point this out discriminately and, unfortunately, it is possible to operate a hospital under our present plans and be quite blind to this fact. Elements which determine the nature and scope of a community health program are:

(1) What is the status of the health needs of the people of the community, both existing and potential?

(a) What is the actual incidence of specific diseases, injuries, and disorders of health with resultant disabilities rate by age, sex, race, occupation, place of occurrence, as well as by occurrence in families and community area groups and with trends?

(b) What are the actual causes of deaths and what are the related factors?

(c) What is the outcome of pregnancy?

(d) What is the incidence of social and economic pathology by families?

(e) What are the prevailing standards of personal hygiene and prevailing practices in regard to maintenance of personal health?

(f) What are the prevailing community and individual practices in environmental sanitation?

Besides appraising the health status and needs, one must also consider the possible ways to meet health requirements, existing and potential resources of the people of the community, and the nature of the community itself.

Since the hospital is truly a social agency designed to meet some of the health needs of the people of the community, this implies that the hospital does part of the job, not the whole. It further implies we must know what the health needs are before it is possible to know what is needed in the way of hospital and other community services.

Another urgent requirement of the future is that proper functional relationships between hospital and related health resources be established, so that health programs can be planned and carried out. If this goal is to be reached, health institution must function in such unity of purpose and harmony that together the various parts make a whole taking care of the health needs of all the people effectively and efficiently.

The parts are: the offices of physicians, dentists, general hospitals, special hospitals, nursing homes, public health, welfare, industry, educational institutions, and others.

Besides realistic analysis of communities to appraise what are the community requirements, hospitals and related persons and groups must reach understandings and agreements in terms of what they want to accomplish as a result of their care: namely, the goals to be reached, as well as the basic steps in carrying out their efforts, with the role of each group and agency agreed upon and understood.

When this is done, there will be a new day in patient care. Instead of giving lip service to good patient care, the creative imagination and resources will be applied so that good patient care is an actuality.

The Hill-Burton program is a means. It is not the end in itself. It *does* have within its framework the elements needed to accomplish the ends, and these elements need to be made available, whether within Hill-Burton or without.

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Problem of Pharmacy Standards In The Small Hospital

By Hazel E. Landeen, R. Ph.*

• The rapid development in standards of pharmaceutical service for hospitals parallels the remarkable growth of the American Society of Hospital Pharmacists. However, a very real problem of pharmacy service still exists for the majority of our hospitals—the two-thirds which are under 100 beds.

Pharmacy in the majority of small hospitals does not exist. A study of the existing problems of pharmacists and their underlying causes would be of great help in organizing a pharmaceutical service in new small hospitals.

A survey by the Association of Western Hospitals on the value of the pharmacist in its community hospitals, ranging in size from 23 to 65 beds, proved that the pharmacist belongs on the team. The survey also bore out the statement that the rapid development of the hospital has made important changes in the practice of medicine and the related professions of nursing and pharmacy.

Advances in drug therapy have been accompanied by large increases in hospital costs of operation. Health-conscious, well-informed, appreciative of improved medical and hospital care, the public is nevertheless keeping a critical eye on the mounting costs of such care. As a result, the pharmacy has become a focal point in the hospital economy. It will become increasingly important because of the current need for hospital facilities.

A recent newspaper account of a 50-bed hospital in a community of 10,000 population described the location of the pharmacy in the medical wing. Such reports are becoming more and more frequent. Twenty years ago a pharmacy in a 50-bed hospital was unheard of.

Unanswered as yet is the manner of providing a pharmacy service. A program of action awaits collection of facts on current needs and available resources.

If each local, state, or regional chapter of the American Society of Hospital Pharmacists would accept responsibility for a study of the small hospital and its problems, the standardization program could approach its goal in a much shorter time.

How can a chapter go about such a project?

The cooperation of the small hospitals should first be enlisted, after explanation of the philosophy and objectives of the minimum standards program and the benefits to be derived. Thereafter, the course of action involves an analysis of jobs to be done in terms of each hospital's needs and resources.

What are some of the problems that may be anticipated?

The following are some of the problems experienced by the writer as a hospital pharmacist, in hospitals ranging in size from 110 to 325 beds, in scattered areas of the United States, over quite a period of time.

Problem No. 1. The pharmacy budget.

Was there one? In most cases, I never knew. Sometimes I suspected there was, because on occasion I would be taken to task for having "gone overboard" on some offers which I had judged to be economically advantageous to the hospital.

What determines the pharmacy budget? If there isn't one, how can operation costs be used in basing charges? What yardstick is employed in figuring charges to patients? The one I used certainly never considered seriously any costs of operation. It was simple—the NARD pricing schedule which I had learned at school. It was the only one we had in those days.

Considering investment, and location and overhead of most of my "drug rooms," I suspect the hospital did not fare too badly on this schedule. (I never saw any balance sheets.) Today's practice requires more astute business methods.

The lack of a budget in concrete form worked another disadvantage on the hospital pharmacists of yesteryear, because no provision was made for improvements such as new equipment, added facilities, additions to the "library" (if such it could be called), or salary increases. Yet the Minimum Standards specify that the hospital shall maintain an adequate pharmaceutical reference library, and they define what minimum references are.

The definition of the supervisory duties and responsibilities of the pharmacist certainly indicates the need of certain equipment and apparatus, although at that time there were no specified lists of equipment, as are provided today. How did the hospital estimate its profit or loss from this operation?

Problem No. 2. Facilities.

Today there is a realization of the relationship between costs of operation and facilities. Are these facilities adequate for conducting an efficient pharmacy in an economical and professional manner? How do they compare with those recommended by the Public Health Service for 50, 100, and 200 beds? Could the existing facilities be remodeled to meet the recommendations? Are they such that the pharmacy could conveniently assume additional services, such as central supply or storeroom?

Today's pharmacy plans are a far cry from drug rooms I have known. In one instance the storeroom was one-half block five flights down; in others, the electric and gas

(Continued on next page)

*Miss Landeen has most recently been employed in Spokane, Wash. She is now living in San Leandro, Calif. This article is adapted from a paper which she presented at the pharmacy section, Association of Western Hospitals, Seattle, Wash., in April, 1956.

heat was provided by the laboratory, dressing room, or diet kitchen, and the refrigerator was in the clinical laboratory.

One could hardly describe such conditions as being conducive to efficient and economical service. We got along because we didn't know any better! We had no time and motion studies in those days, and human relationships had never been heard of.

Problem No. 3. Assistance given the pharmacist in the form of nonprofessional personnel.

Approximately what part of the pharmacist's day is spent on routine tasks which a clerk, a technician, an errand boy, or a porter could do? Some of these duties are:

(a) Pick-up and delivery of ward baskets

(b) Making charges

(c) Checking orders

(d) Putting stock away

(e) Replenishing pharmacy supplies from storeroom stock

(f) Housekeeping duties—such as washing dishes or cleaning up the pharmacy.

To require or expect the pharmacist to do these tasks in addition to his professional duties is wasteful. Certain routine tasks can be performed as well or better by nonprofessional personnel. The pharmacist then would be freed for other professional activities more in keeping with his training and experience, such as keeping residents, nursing divisions, and other departments provided with current information on the new drugs, their uses, safeguards, and precautions in storing and administration.

Other interesting projects which occur to me include the antidote kit for the emergency room and the perennial problem of thermometer disinfectants.

If the pharmacist does not have charge of the central stores, release from routine duties may provide the time necessary for taking over this function. In one of my positions I was very desirous of assuming this obligation in order to have a better control of my stock. (There were just too many persons having keys to stock supply rooms.)

There certainly should be time enough for the pharmacist to make periodic inspections of nursing units (accompanied by the nursing director) to check on outdated drugs, hoarded drugs, and the manner in which drugs are kept.

Pharmacists interested in community activities should be encouraged to participate and given the time to do so—for instance, to make talks before civic and educational organizations and service clubs. Such participation could be an asset to the hospital's public relations program and should be a gratifying experience for the pharmacist.

Problem No. 4. Provision for added professional duties.

Are pharmacy policies and procedure defined in writing? When they are not, it is difficult to explain and require adherence to rules and regulations. Confusion and misunderstandings result.

Certain information pertinent to each department should be made available in printed form—including:

(1) Pharmacy hours

(a) Hours the pharmacist is on duty

(b) Provisions for obtaining drugs after hour whether from a special cupboard of emergenc drugs or from the pharmacy by a designated pe son who will be held accountable for all supplie or drugs given out in the pharmacist's absence.

When no provision is made for this routine, some ver upsetting situations develop, particularly in connectio with pharmacy inventory. For instance, I kept a perpetua inventory of IV solutions all week, so that I would kno at a glance what solutions to order the following Monday One Sunday off duty and all this was for naught.

(2) Floor stock for nursing divisions. How is the kin and amount determined for each unit, and by whom?

(a) Provision for additions and dropping of dis continued items.

(b) Regulations for ordering, storing, and han dling narcotics and barbituates.

(3) Regulations for ordering and delivery. Are there requisition forms to expedite this? Is there a stated time for bringing orders and baskets to pharmacy, or is the pharmacy obliged to wait until all other rush work on floors has been taken care of?

(4) Charges and credits. Is there a policy?

(a) How is this information secured for patients who are going home? Does the hospital give credit for all unused drugs (exclusive of prescription drugs)? One hospital in which I worked credited no tablets. Certainly eye and nose preparations cannot be credited. The hospital pharmacy differs from the retail store in that the patient has not handled the drug. Should credits be restricted only to unopened packages?

(b) Is there a charge for drugs used from floor stock? For which drugs are charges to be made? Who makes these charges or sees that they reach the bookkeeper? Does the bookkeeper have a list of what charges are for various items charged from floor stock? Is this a good policy? (A bookkeeper in one hospital was discovered charging for a 5% Dextrose in saline when the patient had been given Dextran.)

(c) What about refills? Should the nurse be permitted to remove a dose from a container before sending it down for refill? There are two sides to this question! Are orders for a 24-hour supply? If not, why not? Could the amount of credit be held down this way?

(5) Patients' requisitions. Does the nurse copy them from the physician's order on the chart, or are they written in duplicate on special forms by physicians? What about narcotic prescriptions?

(6) Sales to hospital employees and physicians.

(a) Should they be limited to prescription items?

(b) Should they be limited to the employee only, or to his immediate family, or should they include all relatives and friends? (In one hospital in which I was doing relief work, I had so much of this "side business" that I had little time for patients' needs!)

(c) What charge should be made to employees—cost, cost plus 10 percent, 30 percent off retail, or what? How does the employee pay? Is it COD, making the pharmacist responsible? Or does the

charge go to the payroll office, where it is deducted from the employee's next check.

Problem No. 5. Stock control and purchasing.

A formulary, it seems to me, is absolutely essential if there is to be stock control. I could never understand why a formulary was not considered as much a necessity in the small hospital as in the large hospital. The irrational use of many items without previous evaluation serves only to dilute and diminish interest in those who must dispense and administer them.

A small hospital needs a formulary to:

(1) Insure inventory control and reduce the number of outside purchases.

(2) Contribute to rational drug therapy and avoid confusion.

The handbook of hospital policy should define the physician's privileges and restrictions respecting drugs. There should be, except in certain instances, an understanding that medications for hospitalized patients are to be furnished by the pharmacy and not brought in by the physician from outside clinics or stores. In one hospital the administration requested the pharmacy to keep a tally on the frequency with which staff members utilized the pharmacy.

Problem No. 6. Reports, records and forms.

For the small hospital, these should of necessity be kept at a minimum and as simple as possible, in accordance with requirements.

Does the administrator expect and require a monthly financial report on pharmacy operation? In no other way can the pharmacy justify its functions, the role it plays in support of non-revenue departments, and its need for added personnel, space, and equipment.

Forms vary. Two for monthly reports in my experience were drawn up to furnish the administration with facts of purchases made, and from whom credits were given for goods returned, and totals for materials furnished medical, surgical, and other departments.

In a hospital which had no central supply, on a form which I devised in self-defense, I added (a) the amount which disappeared from stock when the pharmacist was off duty (where no requisitions had been left); (b) the number of prescriptions and number of refills (the hospital was interested in determining staff utilization of the pharmacy), and (c) the amount of employee purchases.

In the small hospital with its diversified duties, a daily record expedites preparation of the report at the end of the month. The exact make-up for other forms used for narcotics, barbituates, patient charges, purchasing, and inventory can be modified to suit individual needs.

A form which I found simple, complete, and time-saving, not only for myself but for the person relieving me, was a 3x5 spin file card which listed each item alphabetically and listed other trade names, giving location in pharmacy and selling price in different quantities.

HOW ORGANIZATIONS CAN AID IN PROGRAM

How can hospital pharmacy organizations aid in developing a program for establishing a pharmaceutical service for small hospitals which will meet the Minimum Standards?

A project could be undertaken jointly by the pharmacy organizations in a certain area—for instance, the three Pacific Coast states. A general chairman might be elected to serve the cooperating groups and coordinate their efforts. Then a committee representative from each group should make a survey and acquaint the small hospitals in his area with the purpose of the project and enlist their interest and support.

The program outlined will be determined by the results of the survey or the interest and the needs of the majority. It may be:

(1) Developing a procedural manual on drug policy

(2) Facilities and combination of duties

(3) Forms and accounting records

(4) Special problems, such as evaluation of new drugs, lectures to nurses on new drugs, poisons and antidotes, thermometer disinfectants, etc.

Allocation of responsibility and participation of individuals should be based on a personal inventory of abilities, interests, and talents along with willingness to cooperate in the project.

The program could be implemented by seminars to review, discuss, and evaluate member contributions; workshops conducted for administrators, assistant administrators, and local pharmacists on subjects requested (these might be conducted on invitation in a hospital of each area); inclusion of local pharmacists who expect to serve the hospital in any inservice program to acquaint them with the organization and the responsibilities of the position.

SOURCE MATERIAL FOR PROJECT

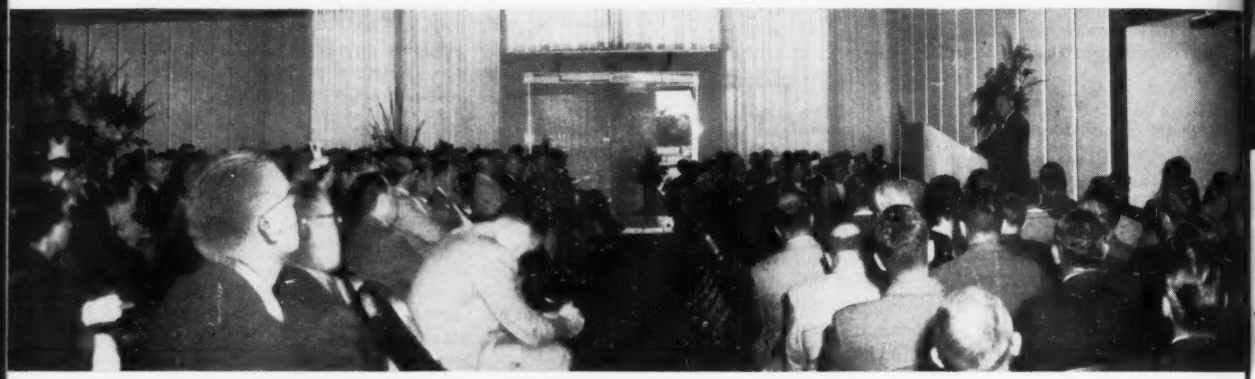
Twenty years ago, pioneering in hospital pharmacy was harassed by many complexities. There was no pattern to follow, and the pioneers had to "learn by doing" every step of the way. Today, thanks to the untiring efforts of Miss Niemeyer and associates (Gloria Niemeyer, secretary, American Society of Hospital Pharmacists—ED.), we have a bibliography which can furnish almost unlimited resource material for any type of educational program undertaken.

The task of bringing pharmacy service to the small hospital is by no means a minor one. It may need to be begun on a small scale to insure success. Those local, state, or regional organizations which do undertake it will be doing pioneer work.

Eminent Surgeon Addresses Dedication

Famous Westminster choir of Princeton, N. J., brought program to impressive conclusion. Choir, directed by John Finley Williamson, left September 30 on its third foreign tour.

Below: Dr. Ravdin delivers dedicatory address in lobby of new plant. Visitors were entertained at luncheon in tent set up on front lawn.



"If the declining trend in ward beds is not halted, it may be that the only true residency programs left after a time will be in military service hospitals or veterans' hospitals..."

• The problem of the decrease in ward beds available for teaching is a grave one for the training of surgeons of the future, I. S. Ravdin, M.D., chairman, board of regents, American College of Surgeons, said in an address dedicating the new administrative, manufacturing, and research facilities of Ethicon, Inc., in Somerville, N. J., September 21.

Dr. Ravdin is John Rhea Barton professor of surgery, University of Pennsylvania, and senior consulting surgeon to the Surgeon General of the Army.

The great growth of insurance plans has been a major factor in reducing the number of ward patients, because more persons are demanding private or semiprivate accommodations, Dr. Ravdin pointed out.

"All too frequently patients are encouraged in these requests by the hospital so as to profit from the use of private accommodations, and the staff doctors who are interested in the private fees," he declared.

"A united stand on the part of the medical community would do much to relieve the situation and would convince the insurance profession of the importance of not pushing surgery back to the preceptorship system."

The current trend toward early specialization in surgery has serious drawdacks, Dr. Ravdin warned. A broad background in general surgery is essential, he emphasized.

In residency training, he continued, "We must constantly keep before us that we are not trying to teach young men merely how to perform an operation, but to select the proper operation, and the proper time, or to reject operation altogether."

Residents can never be given full responsibility for operations on private patients, he said, "for the system will degenerate into something little better than the 'ghost surgery' we are now fighting."

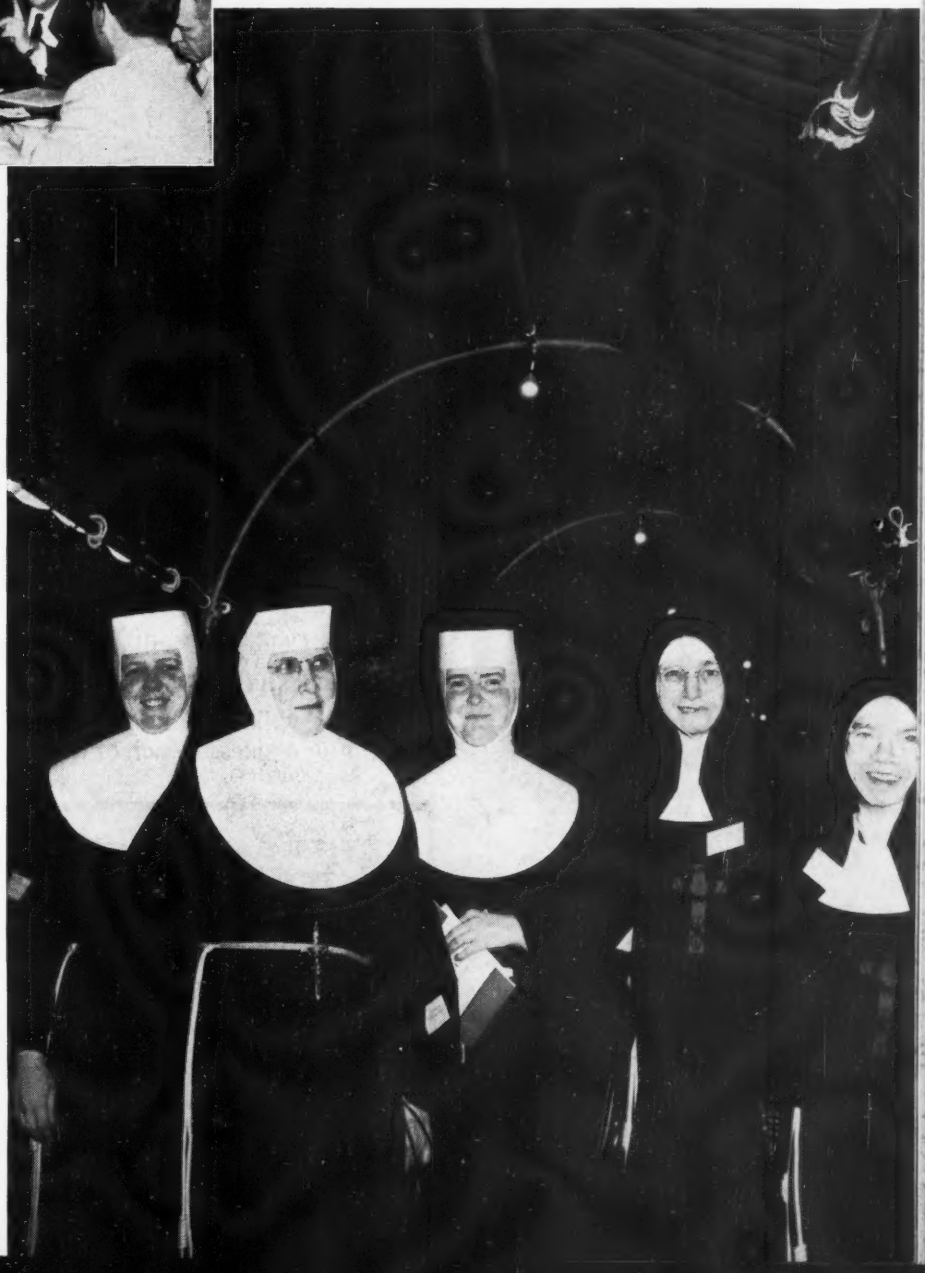
He paid tribute to the contributions of the surgical industry during the last quarter-century to better care of the surgical patient, and also declared that industry has a responsibility to leave good men in teaching and in clinical work instead of "raiding" these services for employees, and to provide funds to permit medical schools to pay better salaries.

More than 200 leading surgeons in the East, as well as executives of Ethicon and Johnson & Johnson and Gov. Robert B. Meyner of New Jersey, attended the ceremony.

Above: Dr. Ravdin (l.) stops to talk after ceremony with Philip B. Hofmann (center), chairman of the board of Ethicon, and one of the guests.

Below: Dr. Ravdin (seated), who was one of surgeons for President Eisenhower's operation for ileitis, answers reporters' questions at press conference. Standing is Ethicon president Richard B. Sellars.

At left: George A. Kellogg (l.), Ethicon vice-president, with Herbert W. Blades, vice-president, Wyeth Laboratories, and Claude V. Swank, vice-president, Johnson & Johnson.



Shown against the setting of the large tent put up for the occasion are (l. to r.): Sister Noreen, Sister Liguori, and Sister Madeline, St. Mary's Hospital, Orange, N. J., and Sister Merici and Sister Birilla, St. Mary's Hospital, Hoboken, N. J.

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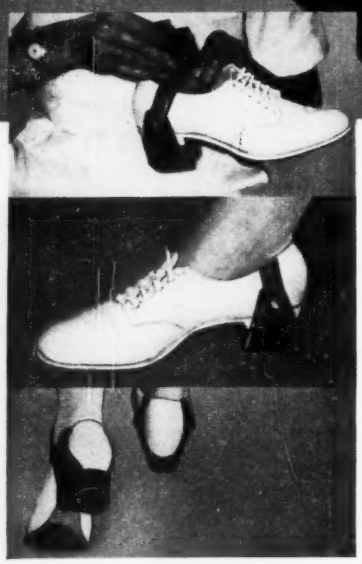

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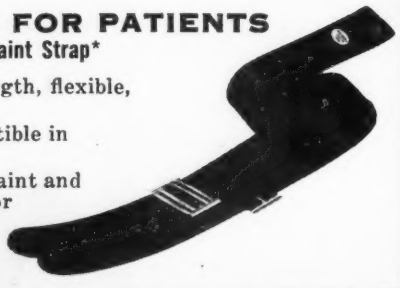

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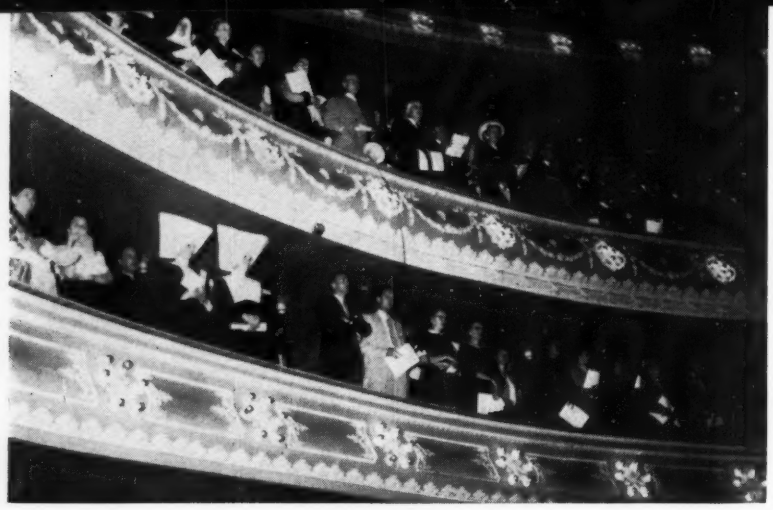


Left: The audience rises as the Rev. Joseph A. George gives the benediction. Then they enter into the singing of the Dutch Prayer of Thanksgiving. Immediately after the hymn the admission of nominees begins.

Convocation Confers ACHA Fellowships on 83

Fellowships were conferred on 83 members of the American College of Hospital Administrators at the 22nd annual convocation in Orchestra Hall in Chicago recently.

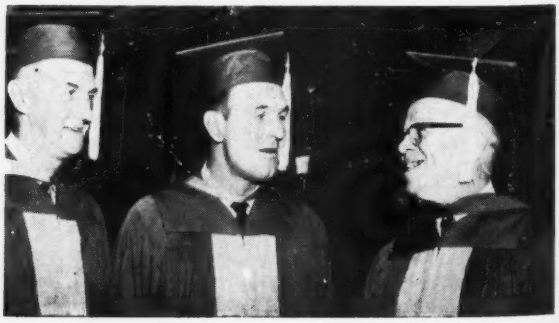
Two hundred candidates were admitted to membership.

At the annual banquet that evening Marshall E. Dimrock, Ph.D., head, department of government, New York University, New York City spoke on "What it Means to be an Administrator."

Below: Candidates recite the pledge of membership after A. J. Swanson, chairman, Ontario Hospital Service Commission, of Toronto and president-elect, American College Hospital Administrators.

Below: Ruth Holmquist, E. R. Moore Co., adjusts the robe of Dean Conley, ACHA executive director, before he leaves the dressing room for the ceremony.

Below: Harold T. Frentzel, administrator, Montgomery Hospital, Morristown, Pa.; Tol Terrell, administrator, Shannon West Texas Memorial Hospital, San Angelo, Tex., and Ray Amber, director, University of Minnesota Hospitals, Minneapolis. Mr. Terrell was named AHA president-elect at the final session of the House of Delegates.



Ready Reference of Hospital Facts

For Planning and Operation

Part IX

By Louis Block, Dr., P.H.

The Average Proprietary Long-Term General Hospital in the United States*

• From 1946 to 1954 the activities of the long-term general hospitals in the United States have changed. This is especially true when one notes the following changes that have occurred in the number of facilities available, their utilization, finances, and personnel. These hospitals now account for 5.8 percent of all hospitals, 4.5 percent of all beds, 4.5 percent of the average days of care provided, 0.7 percent of all admissions, and 3.6 percent of all expenses.

Facilities:

1. The number of hospitals has increased by 17 (from 389 to 406)—an increase of 4.4 percent.

2. The number of beds has decreased by 12,489 (from 83,415 to 70,926)—a decrease of 15.4 percent.

Utilization:

1. The average daily census has decreased by 1,937 (from 62,804 to 60,867)—a decrease of 3.1 percent.

2. The percentage of occupancy has increased from 75.3 percent to 85.8 percent.

3. The number of admissions has increased by 15,883 (from 139,332 to 155,215)—an increase of 11.4 percent.

Finances:

1. Total assets have increased $79,543,000 (from $342,932,000 to $422,475,000)—an increase of 23.2 percent.

2. Total expenses have increased $121,433,000 (from $68,149,000 to $189,582,000)—an increase of 17 percent.

3. Total expenses per patient day have increased $5.56 (from $2.97 to $8.53)—an increase of 187.2 percent.

4. Payroll expense has increased $87,488,000 (from $37,691,000 to $125,179,000)—an increase of 232.0 percent.

5. Payroll expense per patient day has increased $3.99 (from $1.64 to $5.63)—an increase of 243.3 percent.

Personnel:

1. The number of full-time personnel has increased by 18,294 (from 28,000 to 46,294)—an increase of 65.3 percent.

2. The number of full-time personnel per 100 patients has increased by 31 (from 45 to 76)—an increase of 68.9 percent.

The following presents some pertinent facts concerning the average long-term general hospital in the United States.

The Average Proprietary Long-Term General Hospital in the United States*

Facilities:

1. Number of beds	44
2. Number of bassinets	1
3. Percent of hospitals with infant incubators	5.7
4. Number of incubators	1
5. Number of major operating rooms	1
6. Number of minor operating rooms	1

Utilization:

1. Number of annual adult admissions	88
2. Average daily adult census	35
3. Percentage occupancy	80.3
4. Average length of adult stay in days	146.9

Financial:

1. Total assets	$119,388
2. Plant assets	$79,552
3. Percent plant assets of total assets	66.6
4. Total annual expenses	$78,871
5. Total expenses per patient day	$6.12
6. Annual payroll	$40,953
7. Payroll per patient day	$3.18
8. Percent payroll of total expenses	52.0
9. Percent hospitals requiring funds for replacement	44.4
10. Number of $ per hospital required for replacement	$24,667

Services:

1. Percent of hospitals offering:	
a. Blood bank	9.1
b. Cancer clinic	0
c. Central supply room	12.7
d. Children's education program	0
e. Clinical laboratory	20.0
f. Dental department	5.5
g. Electrocardiograph	23.6
h. Electroencephalograph	1.8
i. Hospital auxiliary	1.8
j. Library, medical	9.1
k. Library, patient	20.0
l. Medical record department	38.2
m. Mental hygiene clinic	0

*Based on information in American Hospital Association's Administrators Guide Issues (1951-1955)

(Continued on next page)

READY REFERENCE Continued

n. Metabolism apparatus	16.4
o. Occupational therapy department	29.1
p. Outpatient department	7.3
q. Pharmacy	20.0
r. Physical therapy department	29.1
s. Postoperative recovery room	5.5
t. Premature nursery	0
u. Radioactive isotopes	0
v. Rehabilitation department	14.5
w. Social service department	10.9
x. X-ray diagnosis	18.2
y. X-ray routine chest on admission	3.6
z. X-ray therapy service	1.8
aa. Organized training programs for auxiliary nursing personnel	1.4

Personnel:

1. Number of full-time personnel	21
2. Number of full-time personnel per 100 patients	59
3. **Nursing personnel:**	
a. Total graduate nursing personnel	3
(1) Administrative graduate nursing personnel	0
(2) Full-time instructors	0
(3) Supervisors and assistants	1
(4) Head nurses and assistants	0
(5) General duty nurses full-time	1
(6) General duty nurses part-time	1
(7) Nurses not classified	-
b. Private duty nurses	2
c. Practical nurses	5
d. Attendants	2
e. Nurses aides	7
f. Ward maids	1
g. Orderlies	2
4. **Medical technologists:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	0
d. Other part-time	1
5. **X-ray technicians:**	
a. Registered full-time	0
b. Registered part-time	1
c. Other full-time	0
d. Other part-time	1
6. **Occupational therapists:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	0
d. Other part-time	1
7. **Physical therapists:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
8. **Dietitians:**	
a. Full-time	1
b. Part-time	0
9. **Medical social workers:**	
a. Full-time	1
b. Part-time	0
10. **Pharmacists:**	
a. Full-time	0
b. Part-time	0
11. **Medical record librarians:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	0
d. Other part-time	1
12. **Other medical record personnel:**	
a. Full-time	0
b. Part-time	1

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SOILED NEEDLE CONTAINER
CAPACITY: 60 to 80 Needles up to 2" long
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— Departmental —

Governing board:

1. Number of members	5

Medical staff:

1. Percent of hospitals with chief of staff	54.0
2. Percent hospitals with chiefs of services	24.0
3. Percent hospitals with written set of staff regulations	36.0
4. Percent hospitals with regularly scheduled meetings of staff	34.0
5. Percent of hospitals with standing committees of the staff	20.0
6. Percent of hospitals with executive committee of staff	18.9
7. Percent of hospitals with medical record committee of staff	4.4
8. Percent of hospitals with education committee of staff	2.2
9. Percent hospitals with dietary committee of staff	5.6
10. Percent hospitals with nursing committee of staff	11.1
11. Percent of hospitals with other committees of staff	2.2
12. Number of staff physician appointments	12

5
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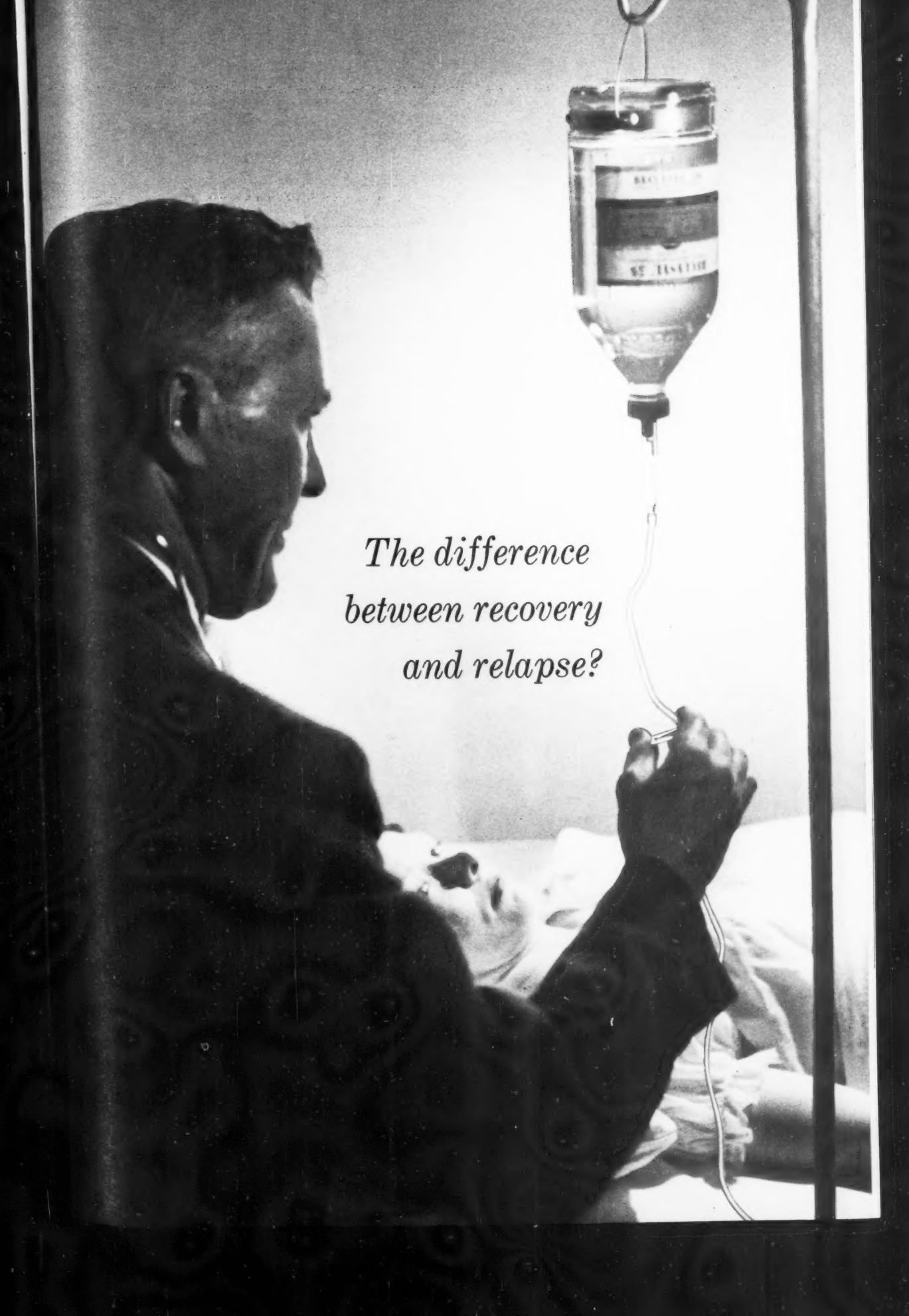
OPICS


The difference
between recovery
and relapse?

Team your carbohydrate therapy with supporting B-Complex

PARENTERAL DEXTROSE is a familiar routine. Probably you've called for it many times. Yet carbohydrate alone should not necessarily be considered self-sufficient. It requires the support of adequate B-Complex reserves in your patient.

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Riboflavin	10 mg.
Nicotinamide	250 mg.

BECLYSYL®

Supplied in:
5% or 10%, in saline or in water; 500-cc. or 1000-cc. bottles. Also Alcohol, 5% in BECLYSYL, 5% in Water, in 1000-cc. bottles. Where invert sugar with B-Complex is preferred, specify VERCLYSYL®.

611029

13. Number of active staff	3
14. Number of active staff per 100 beds	5
15. Number of associate staff	1
16. Number of associate staff per 100 beds	1
17. Number of courtesy staff	5
18. Number of courtesy staff per 100 beds	9
19. Number of consultant staff	2
20. Number of consultant staff per 100 beds	4
21. Number of honorary staff	0
22. Number of honorary staff per 100 beds	0
23. Number of other staff appointments	2
24. Number of other staff appointments per 100 beds	3
25. Percent hospitals having psychiatrist on staff	37.3
26. Percent hospitals reporting surgical restrictions on staff	46.2
27. Percent hospitals permitting non-staff members to practice in hospital	80.0
28. Percent of hospitals providing examining rooms for ambulatory patients of medical staff	19.4
29. Percent hospitals having private physicians' offices in hospital or on hospital grounds	8.7
30. Percent hospitals having x-ray facilities available to private ambulatory patients of staff	58.3
31. Percent hospitals having laboratory facilities available to private ambulatory patients of staff	33.3

Administrator:

1. Percent hospitals in which chief administrative officer is a physician	22.9
2. Percent hospitals in which chief administrative officer is a graduate nurse	35.4
3. Percent hospitals in which chief administrative officer is other than a physician or nurse	41.7
4. Percent hospitals in which chief administrative officer is a graduate of college course in hospital administration	11.6
5. Percent hospitals in which chief administrative officer is a male	47.1
6. Percent hospitals in which chief administrative officer is a female	52.9
7. Percent hospitals in which one or more persons perform full-time as assistant administrator	64.7
8. Percent hospitals having administrative staff member on duty at night	44.9
9. Percent hospitals delegating administrative responsibility to night supervising nurse	50.7

Laboratory:

1. Percent hospitals having all tissue removed at surgery routinely examined by a pathologist	25.0
2. Percent hospitals having urinalysis on all admissions	25.0
3. Percent hospitals having blood count on all admissions	16.1
4. Percent hospitals having serological examinations for syphilis on all adult admissions	7.1
5. Percent hospitals having electrocardiographs on all admissions over 45 years of age	1.8
6. Percent hospitals having Rh grouping on all pregnancy cases	1.8
7. Percent hospitals having preoperative blood groupings on all surgical cases	0.0
8. Percent hospitals having preoperative coagulation on all tonsillectomies	3.6
9. Percent hospitals having postoperative urinalysis on all surgical cases	0.0
10. Percent hospitals having no tests without doctors' orders	73.2

Pharmacy:

1. Percent hospitals operating pharmacies	10.9
2. Of those hospitals operating pharmacies, percent having full-time licensed pharmacist	16.7
3. Of those hospitals operating pharmacies average number of full-time pharmacists	1
4. Of those hospitals operating pharmacies, percent manufacturing parenteral solutions	0
5. Percent of hospitals having formulary	21

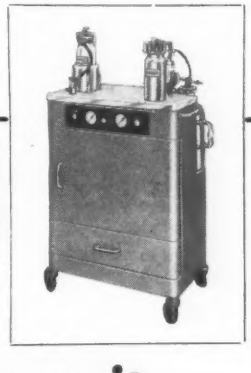
Outpatient Department:

1. Percent hospitals having one or more outpatient clinics	5.1
2. Number of annual clinic visits	20
3. Number of annual private out-patient visits	439
4. Number of annual emergency visits	48

Medical Records:

1. Percent hospitals microfilming

(Continued on next page)



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medical records	1.9
2. Number of annual deaths	21.3
3. Number of annual autopsies	0
4. Number of annual deaths released to legal authorities	10
5. Percent hospitals using Standard Nomenclature of Diseases and Operations	66.7

Admitting:

1. Percent hospitals using typewriter system for duplicating admitting records	47.1
2. Percent using mimeograph system for duplicating admitting records	3.9
3. Percent hospitals using liquid and gelatin system for duplicating admitting records	0
4. Percent hospitals using plate imprint system for duplicating admitting records	0
5. Percent hospitals using hand entry system for duplicating admitting records	43.1
6. Percent hospitals using other or combinations of above for duplicating admitting records	5.9
7. Percent hospitals routinely treating the following types of patients:	
a. Alcoholics	9.7
b. Cancer	75.8
c. Cardiac	77.4
d. Dermatologic	24.2
e. Drug addiction	6.5
f. Epileptic	17.7
g. Gynecologic	9.7
h. Isolation (contagion)	0
i. Leprosy	0
j. Medical	80.6
k. Mental deficient	22.6
l. Neurologic	30.6
m. Obstetric	4.8
n. Ophthalmic	11.3
o. Orthopedic	33.9
p. Otorhinolaryngologic	9.7
q. Poliomyelitis	4.8
r. Psychiatric	12.9
s. Surgical	17.7
t. Tuberculosis	0
u. Urologic	29.0
v. Venereal disease	0
w. Acutely ill	25.3
x. Chronically ill	86.7
y. Students exclusively	0
z. Convalescent and rest.	86.7
aa. Geriatic	76.0
bb. Industrial	9.3
cc. Pediatric	2.7
dd. Prisoners exclusively	0

Accounting:

1. Percent hospitals with ending date of fiscal year in—	
a. January	0
b. February	2.2
c. March	0
d. April	4.3
e. May	6.5
f. June	13.1
g. July	0
h. August	4.3
i. September	6.5
j. October	2.2
k. November	2.2
l. December	58.7
2. Percent hospitals which calculate depreciation	87.8
3. Percent hospitals which fund depreciation	22.2
14. Percent hospitals operating under formal budgets	32.1
15. Percent hospitals using AHA chart of accounts	20.8

Purchasing:

1. Percent hospitals with central purchasing department	96.2
2. Percent hospitals with central purchasing departments with full-time purchasing agent	27.5
3. Percent hospitals with central purchasing department with part-time purchasing agent	54.9
4. Percent hospitals with central purchasing department with no reply as to purchasing agent	17.6

Public Relations:

1. Percent hospitals using booklet for employees	12.3
2. Percent hospitals using booklet for patients	17.5
3. Percent hospitals using regularly published house organ	2.2
4. Percent hospitals using printed annual report	10.1
5. Percent hospitals using patient opinion poll	7.3
6. Percent hospitals using personnel opinion poll	16.9
7. Percent hospitals using medical staff opinion poll	18.2
8. Percent hospitals using community opinion poll	1.8
9. Percent hospitals using none of these	74.5

Dietary:

1. Percent hospitals with central food service layout	97.6
2. Percent hospitals with decentralized food service layout	2.4
3. Percent hospitals with selective menus for all patients	52.8
4. Percent hospitals with selective menus for private patients only	8.3
5. Percent hospitals not offering selective menus	38.9
6. Percent hospitals with manual and centralized dishwashing	51.1
7. Percent hospitals with manual and decentralized dishwashing	2.2
8. Percent hospitals with mechanical and centralized dishwashing	51.1
9. Percent hospitals with mechanical and decentralized dishwashing	2.2

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen	36.4
a. Number of pounds processed per week	1,278
b. Number of pounds processed per patient day	4.0
2. Percent hospitals operating own laundry and processing only a part of soiled linen	22.7
a. Number of pounds per week	1,032
b. Number of pounds per patient day	4.0

3. Percent of hospitals not operating own laundry 40.9
   a. Number of pounds processed per week 871
   b. Number of pounds processed per patient day 3.3

Auxiliaries:

1. Percent hospitals having organized auxiliaries 3.2

Safety:

1. Percent hospitals with organized safety committee 66.0
2. Percent hospitals with written fire emergency and evacuation plans 80.4
3. Percent hospitals with regularly scheduled fire drills 60.9
4. Percent hospitals having own written plan for mobilization of employees and medical staff 27.1
5. Percent hospitals whose written plan is integrated in master community plan 18.6
6. Percent hospitals represented on a community disaster planning committee 30.4

Religious:

1. Percent hospitals with a chapel 7.0
2. Percent hospitals with a meditation room for prayer 16.7
3. Percent hospitals with organized visiting clergy staff 33.3
4. Percent hospitals having chaplains available 86.2
5. Percent hospitals with full-time chaplains 1.5
6. Percent hospitals with part-time chaplains 9.2
7. Percent hospitals with chaplain on call only 75.4

South Dakota Hospitals Attend Fire-Fighting School

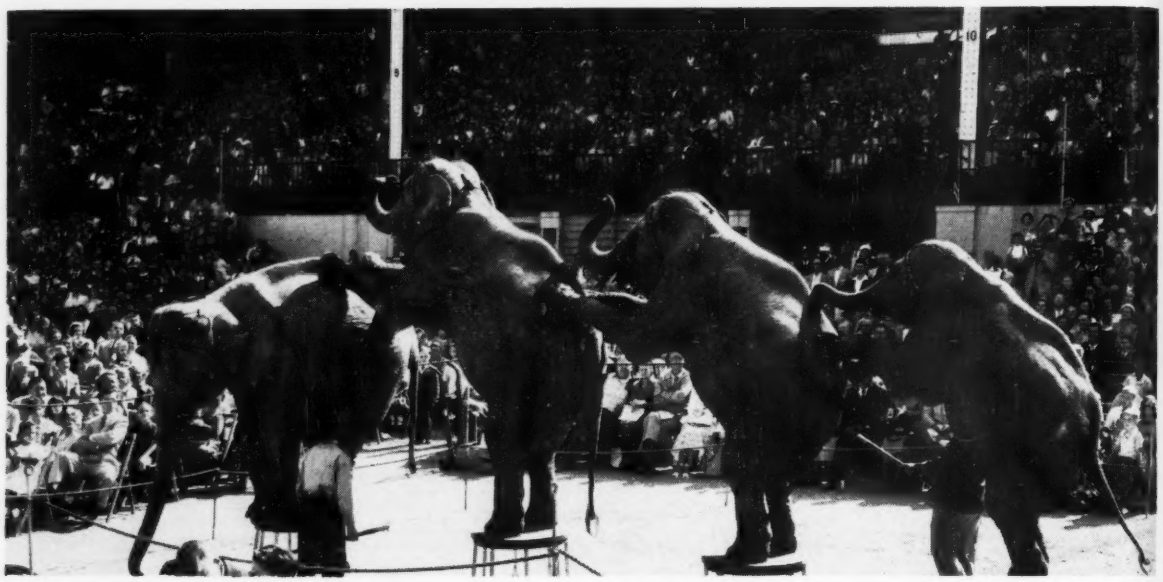
What is believed to be the first "Fire and Evacuation School" ever conducted on a statewide level was held August 13-18 at St. John's Hospital, Huron, S. D.

Twenty-two hospitals sent 104 participants to the hospital fire-fighting and patient removal school, conducted by Lt. Robert McGrath, hospital inspector, Fire Prevention Bureau, Chicago.

Forty-three firemen from 10 cities and towns also participated in the instructions and drills.

Above: Lois Rounds and Janet Kauth, both R.N.'s at St. John's Hospital, Huron, demonstrate one of the six basic carries taught by Lt. McGrath. In the background is part of the group attending one of the three daily sessions. Climaxing the "Fire and Evacuation School" was a public demonstration before over 200 observers by five four-member teams of registered nurses and student nurses from St. John's Hospital and School of Nursing. In slightly over a minute, each team evacuated three patients, including one from a burning bed; smothered three wastebasket fires and the burning bed with a blanket, and put out five other fires with a variety of extinguishers and a fire hose.

Left: Using CO_2 extinguishers to put out simulated gasoline fires are Thomas Kujawa and Sheila Schiltz, seniors at St. John's Hospital School of Nursing, Huron.



Above: Star Nite three years ago added matinees with a circus theme to accommodate the increasing demand, the real stars being visual acts and children's television celebrities. Roosevelt raceway and Belmont racetrack contributed their facilities.

"Hospital Star Nite"
Nets $400,000 for New York Hospitals

Hospital Star Nite—the Long Island Industry-Labor Fund's annual outdoor talent charity show—attracted 100,000 industrial workers with its two performances recently at Roosevelt Raceway, Long Island.

This affair started out seven years ago as a kick-off event to launch a fund-raising drive to build the North Shore Hospital in Manhasset, Long Island. Now it has expanded to include all 19 voluntary hospitals in Nassau and Suffolk counties. The proceeds have increased from $9,000 originally to an anticipated $400,000 this year.

During the past six years $1,270,000 in Star Nite profits has been distributed by the Fund to voluntary nonprofit institutions in both counties. Over $20,000,000 has been raised in individual drives by local hospitals for expansion projects, with Hospital Star Nite serving as the attention-getting promotion for all the hospitals.

Top stars of television and Broadway are featured in Hospital Star Nite. For his $5 contribution the worker receives two seats at the evening show or four seats for the children's matinee. He has a chance to win one of over 200 prizes with a total value in excess of $35,000. In addition, there are plant visits by celebrities and kick-off cocktail parties for campaign leaders, and a general feeling of excitement and enthusiasm is created.

Costs of the annual shows, prizes, administration, and informational programs add up to only 17 percent of the funds raised.

Radio and TV stars Tex and Jinx Falkenburg McCrary have been the volunteer producers of the show each year, and have used their shows to promote the event as well as the hospitals' needs.

Leon A. Swirbul, president, Grumman Aircraft and head, regional hospital committee, enlisted the support of his company and other industries.

Organized labor has given its enthusiastic cooperation and support from the beginning. The name was changed from L.I. Industry Fund to L.I. Industry-Labor Fund for Hospitals.

Above: Jinx Falkenburg McCrary (r.) and Tex, hospital Star Nite producers, help sell the first Industry-Labor fund membership in an aircraft factory to kick off the annual drive among the manufacturing, utility and construction plants and projects on Long Island.

Right: Paul Townsend, executive director, Industry-Labor fund, discusses Star Nite with Jackie Cooper, who has starred in several of the shows, and Mrs. Alfred G. Vanderbilt, who has been co-chairman of the annual benefit since it was organized in 1950.

Above: George A. Meany (center) president, AFL-CIO, presents Leon Swirbul, president, Grumman Aircraft, the International Association of Machinists Award, for his work in founding and expanding the Long Island Industry-Labor fund for hospitals. Pictured at right: Robert Forrester, fund secretary, and secretary-treasurer, Nassau-Suffolk Building Trades Council.

Below: Elder statesman Bernard Baruch is shown with fund president, Mundy I. Peale (l.), head, Republic Aviation, and Henry Viscardi (r.) president, Abilities Inc. Abilities Inc. has a plant in West Hempstead. All the employees are handicapped and have averaged years in hospitals. The plant is the first plant to subscribe 100 percent to the fund.

Above: Over 35,000 seats are provided at a single show. Several shows are given to take care of all the supporters of Hospital Star Nite. Among the stars that perform under the stars on stages built at Roosevelt Raceway and Belmont Racetrack are: Steve Allen, Herb Shriner, Peter Hayes and Mary Healy, Paul Winchell, Sam Levinson, Bambi Lynn & Rod Alexander, Sheree North, Dan Dailey, Ezio Pinza, Phil Silvers, Vic Damone, Patti Page, Perry Como, Tony Martin, Lena Horne, Eartha Kitt, Frank Sinatra, Terry Moore.

Snapped by TOPICS at the AHA

For TOPICS' comprehensive report on the 1956 AHA meeting, held in Chicago, September 17-20, see pages 17-32 of the October issue.

Auxiliary Elevated To AHA Council

Discuss Successful Projects, Fund-Raising Plans

Women from almost all the states, Alaska, Hawaii, Canada, and Mexico attended the ninth annual conference of hospital auxiliaries. The Committee on Hospital Auxiliaries became the seventh official council of the AHA. Theme for auxiliaries for next year is "Building in the Community for Hospital Careers."

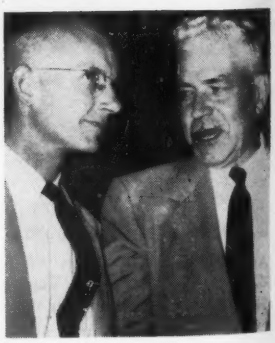
Many project ideas were discussed and details of specific projects presented. These projects included: (1) how volunteers can assist in relaxing neurasthenic hospital patients; (2) how a successful annual "gypsy fair" is conducted in Norwich, Conn.; (3) how an auxiliary assisted in making foreign medical staff members and employees feel that they were a part of the community; (4) what role the auxiliary can play in disaster planning; how volunteers can be effective salesmen for the hospital when they know and understand the principles of its intricate operations.

Above: Sister Odilia, assistant administrator, and Sister M. Vetusa, administrator, St. Catherine's Hospital, East Chicago, Ind., stop to admire the century-old clock in the lobby of the Stock Yard Inn. Sister Vetusa is president of the Indiana Hospital Association.

Left: At auxiliary function, Mrs. Arthur B. Slack, St. Luke's Hospital Woman's Auxiliary, Denver, Colo., chats with Mrs. Rose Swartz, Queens Hospital, Honolulu, Hawaii.

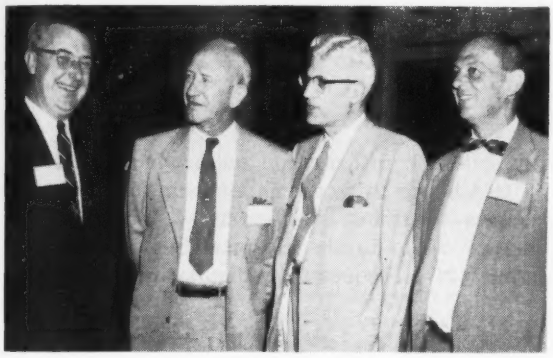
Robert T. Ingram, M.D., assistant administrator, Royal Victoria Hospital, Montreal, Canada speaks with Robert Collier Page, M.D. medical management consultant, New York City, after the AHA banquet.

Fund-raising ideas included: (1) stock-raising teas for gift shops — to which each person attending brings a handmade article for sale in the gift shop; (2) distribution by subscription of a newsletter when a meeting cannot take place or members did not attend a scheduled meeting; (3) auxiliary benefit day at the local theatre or golf club; (4) the "tease tea" — at which purchasers of tickets receive a chance on the clothing and accessories worn by a model; (5) operation of a small photographic studio for taking baby identification pictures.



Right: William L. Wilson, administrator, Mary Hitchcock Hospital, Hanover, N. H. and Lester E. Richwagen, administrator, Mary Fletcher Hospital, Burlington, Vt. get together at an AHA party.

Above: Glendal D. Nichols, administrator, 4450th USAF Hospital, Langley (Va.) Air Force Base, and T. H. Poe, administrator, USAF Hospital, Patrick (Fla.) Air Force Base, at the Federal Hospital Executives luncheon.



Above: Charles Wynne, administrator, Waterbury (Conn.) Hospital, Chalmer Davee, M.D., VA Center, Hot Springs, S. D., Stuart Knox, Connecticut Hospital Association, New Haven, Conn. and Andre Blumenthal, Norwalk (Conn.) Hospital, get together before an AHA luncheon.

Below: Robert Page, M.D., medical management consultant, New York City; Walter M. Oliver, director, Palo Alto (Calif.) Hospital; and Anthony J. J. Rourke, M.D., hospital consultant, New Rochelle, N. Y.

Right: Mrs. F. F. Barnes, chairman of baby photos, Georgetown University Hospital, Washington, D.C. and Mrs. J. R. Ready, planning committee, gift shop, Providence Hospital, Washington, D.C., get together at an auxiliary tea.

Below: Louis Block, Dr. P.H., tells Arthur Allen, administrator, Rockaway Beach (N.Y.) Hospital, and Douglas West, hospital program director, U. S. Public Health Service, New York City, about his book Hospital Trends, published by HOSPITAL TOPICS.

Left: William G. Kirby, board member, and James H. Lincoln, chairman, capital improvement committee, Wayne County General Hospital, Detroit, discuss the $9,500,000 500-bed hospital they are building.

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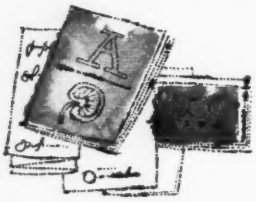

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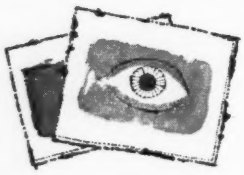
ANATOMICAL SLIDES



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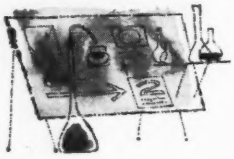

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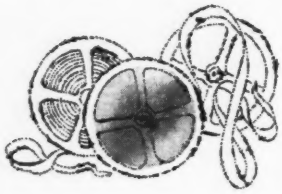

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HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P. H.

Average Length of Patient Stay

Of late, much emphasis has been placed on average length of patient stay. In recent years it has shown a marked decrease in general hospitals. Responsibility for this decrease has been attributed to the tremendous strides in the development and use of antibiotics and other changes in medical practice.

How does this decrease affect hospital planning and operation? From the viewpoint of planning, it means that more people can be cared for in the same number of facilities. This fact must be remembered when studying community, state, or national needs.

From the viewpoint of hospital operation, it means a tremendous concentrat' of care into a shorter period of time, resulting in an accompanying increase in personnel to provide such care. This in turn leads to a higher cost of operation and a corresponding increase in costs per patient day.

In short, changes in length of stay have definite planning, staffing, and financial implications for hospitals plus certain community-wide implications. Decreased length of stay means that wage earners are in a position to return to gainful employment earlier, thereby increasing the stability of the labor force and keeping manpower at a higher productive level.

It also means that when it is the wage earner who requires hospitalization, there is, on the average, less loss of income. This in turn helps to increase the ability of the patient to pay for care. This latter financial implication is somewhat offset by the increased daily cost of receiving such care.

The term itself means the average number of days of service provided to each in-patient during a specified period of time. For the general hospital, it is computed "by dividing the total number of patient-days (excluding newborn) during a period by the total number of discharges and deaths (excluding newborn) during the same period."[1/] For institutions with a long average length of stay, it is recommended that it be determined by using the exact number of days of care given to those patients discharged during that period.

The fact that the AHA makes a classification distinction of hospitals by average length of stay is significant. In doing so, it recognizes certain basic differences in the administration and provisions of services between long-stay and short-stay institutions. Relatively small changes in length of stay have a much more marked effect upon the planning and operation of general hospitals than they have on long-stay hospitals, such as nervous and mental and tuberculosis. For that reason this presentation is limited to general hospitals.

A study of available data relating to length of stay reveals two broad perspectives of approach to the analysis of such information. One is its relationship to disease, and the other to the organizational setting or grouping of the facilities or resources. Regarding the former, there is little available information except from special groups; for the latter more general information is available.

Let us look at the variations which have occurred in general short-term hospitals;

1. Average length of stay is decreasing. This is true for all control groups.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Control[2/]
General and Special Short-Term Hospitals

Year	Total	Nonprofit	Proprietary	Governmental
1946	9.1	8.8	6.6	11.4
1947	8.0	8.1	6.4	9.2
1948	8.7	8.5	5.8	11.0
1949	8.3	8.0	5.6	11.2
1950	8.1	7.7	5.6	10.7
1951	8.3	7.8	5.8	11.1
1952	8.1	7.7	5.5	10.7
1953	7.9	7.6	5.6	10.3
1954	7.8	7.5	5.6	9.9
1955	7.8	7.5	5.6	9.7

(Continued on next page)

The longest length of stay occurs in government general hospitals and the shortest in proprietary hospitals. A stabilizing pattern appears to be developing in the Non-profit and Proprietary hospital groups.

2. Average length of stay increases with the average size of the hospital. This holds true for all control groups.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Size, 1955 [2/]
General and Special Short-Term Hospitals

Size	Total	Nonprofit	Proprietary	Governmental
Under 25	5.0	5.3	4.7	5.2
25-49	5.5	5.8	5.2	5.4
50-99	6.3	6.5	5.9	6.0
100-199	7.1	7.1	6.7	11.5
200-299	7.7	7.6		
300- 499	8.6	8.3		
500 plus	13.1	10.3		

3. Average length of stay shows regional variations.

Average Length of Stay (In Days) in General and Special Short-Term Hospitals by Region, 1955 [2/]
General and Special Short-Term Hospitals

Region	Total	Nonprofit	Proprietary	Governmental
New England	8.4	8.0	6.5	14.6
Middle Atlantic	9.6	8.8	7.2	15.6
South Atlantic	6.9	6.8	6.0	7.3
E.N. Central	7.8	7.6	6.8	8.8
E.S. Central	6.2	6.5	5.5	6.1
W.N. Central	8.0	7.7	6.6	9.7
W.S. Central	6.3	6.0	4.8	8.3
Mountain	6.6	6.4	4.3	8.1
Pacific	7.6	6.3	5.0	13.9

4. Average length of stay varies with type of diagnosis.

Average Length of Stay in General Hospitals
By Diagnosis, 1954 [3/]

Medical	14.7 days
Surgical	10.5 days
Obstetrics	5.7 days
Gynecology	7.2 days
Pediatrics	8.3 days
Genitourinary	12.5 days
Orthopedic	15.0 days
Eye, Ear, Nose and Throat	2.5 days
Ophthalmology	8.5 days
Other medical services	10.5 days

5. Average length of stay is not the same for all types of accommodation.

Average Length of Stay in General Hospitals
By Type of Accommodation, 1955 [3/]

Private	10.4 days
Semi-Private	8.9 days
Private Ward	7.8 days
General Ward	12.2 days

6. Average length of stay differs with the financial status of the patient.

Average Length of Stay in General Hospitals
By Financial Status of Patient, 1955 [3/]

Patients paying regular rate	9.3 days
Patients covered by Assoc. Hosp. Ser.	8.9 days
Patients covered by Workmen's Comp.	11.3 days

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Patients who are N.Y.C. public charges	13.4 days
Free patients	16.2 days
Commercial patients	9.6 days

These variations are important and cannot be disregarded when discussing average length of stay. In addition to their direct application and implications, these differences are important in that they point out the dangers and limitations that are inherent in an over-all average. By itself, the over-all average tells only part of the story.

Another point of information about length of stay that has a direct relation to hospital operation and patient movement is the proportion of patients that stay in the hospital one day, two days, three days, and so forth. Some special studies made by the Rochester Hospital Council and the Associated Hospital Service of New York reveal that approximately 25 percent of the patients admitted stay only two days; between ½ and ⅔ of the patients are discharged within six days and better than 95 percent within 30 days. The greatest movement of patients occurs within the first five days.

Next Month:
Hospital Expenses

REFERENCES

1/ Handbook on Accounting, Statistics, and Business Office Procedures for Hospitals: Section 1, Uniform Hospital Statistics and Classification of Accounts, published by the AHA.
2/ Hospitals, Journal of the AHA: Guide Issue, August 1, 1956: Part Two
3/ United Hospital Fund of New York: Bulletin #184, March 6, 1956

Family Troubles Explain Delinquent Payments

Handling accounts receivable in one Eastern hospital is never dull, judging by a letter sent to the business office, which subsequently found its way to a firm of accountants and auditors in New York City.

An actual copy of the letter follows:

Mrs. _____:

Sorry I have delinquent in payments. During the Holidays had quite a bit of trouble as if everyone doesn't. My son was shot the 31th Dec.

Mr. _____ take sicke 24th. Then I still have to go back forth to the Hospital. Doing much better now. Will send you more on this soon a possible.

Just to let you know I have neglected this on purpose.

Sincerely,
Mrs. _____

VA Appoints Houtchens to Clinical Psychology Post

H. Max Houtchens, Ph.D., has been appointed chief, VA clinical psychology division, central office, Washington, D.C., succeeding H. M. Hildreth, Ph.D., who has accepted an appointment with the U.S. Public Health Service.

Prior to his appointment, Dr. Houtchens had served as chief consulting psychologist to VA's clinical psychology division in the psychiatry and neurology service, Washington, D.C.

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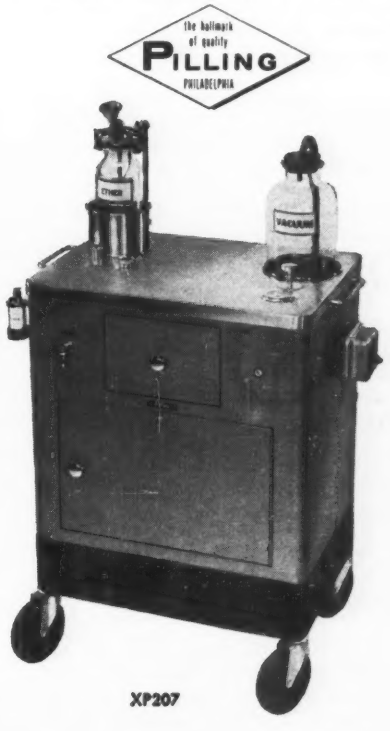

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Personally Speaking

Henry Aloway—is administrator of the new Tyler Holmes Memorial Hospital, Winona, Miss. He was formerly at Oxford (Miss.) Hospital.

Mrs. Ann C. Amatore—has been appointed administrator, Valley Hospital, Van Nuys, Calif.

Alice M. Anderson, R.N.—is now director of nursing service, Good Shepherd Hospital, Hermiston, Ore. Formerly she was superintendent, Goshen County Memorial Hospital, Torrington, Wyo.

Milton M. Anderson—has been named administrator, Park Hospital, Long Beach, Calif.

Gray Bingham—is the new administrator, Bourbon County Hospital, Paris, Ky. He was formerly with Ingleside Lodge Hospital, South San Gabriel, Calif.

F. V. Bokas—has been appointed to the newly created post of business manager, Baptist Hospital, Pensacola, Fla.

Douglas R. Bond—has become chief technician, x-ray department, Macon (Ga.) Hospital. He served as chief x-ray technician, M. D. Anderson Hospital for Cancer Research and Treatment, Houston, Tex.

Mrs. Royal Briggs—has been appointed superintendent, Crystal Falls (Wis.) Municipal Hospital. She succeeds **Mrs. Mary Sullivan.**

Kenneth Brooks—is administrator, Marcus J. Lawrence Memorial Hospital, Cottonwood, Ariz., succeeding **Frank E. Snider.**

Thomas W. Bruny—has been named business manager, Wyoming State Hospital, Evanston, Wyo. He was formerly chief clerk, Wyoming Pioneer Home, Thermopolis.

Mrs. Ruth Buckley—is now administrator, Suburban Hospital, South Gate, Calif.

Philip E. Buckman, D.O.—has been named administrator, Exeter (Calif.) Memorial Hospital.

J. Walter Burdette, M.D.—is director, Saint Louis (Mo.) University surgical service, VA Hospital, and professor of clinical surgery, Saint Louis University School of Medicine. He was formerly chairman, department of surgery, University of Missouri School of Medicine.

Donald O. Burst, M.D.—is the new president of the medical staff, St. Joseph Hospital, Kirkwood, Mo.

R. Bruce Butters—is administrative assistant, White Cross Hospital, Columbus, Ohio. He was formerly administrative resident, Vancouver (B.C.) General Hospital.

Hazel Carbaugh — administrator, Alleghany Memorial Hospital, Covington, Va., has resigned.

Mrs. Stella Cary—has been appointed administrator, Villa View General Hospital, San Diego, Calif.

I. Cassini—has been named administrator, Eastside General Hospital, Los Angeles.

Ben H. Chamberlain, M.D.—is now administrator, Alhambra (Calif.) Community Hospital.

Mrs. Gladys Clark—has been named superintendent of nurses, Santiam Memorial Hospital, Stayton, Ore., succeeding **Mrs. Mabel Sayre.**

Lester L. Deutsch—is administrator, Inglewood (Calif.) General Hospital.

John P. Dowling—has succeeded **George D. Cutler, M.D.**, as administrator, Milton (Mass.) Hospital. He served his residency at Butler (Pa.) County Memorial Hospital.

Earl G. Dresser— is administrator, McDonough District Hospital, McComb, Ill. He was previously assistant administrator, Asbury Methodist Hospital, Minneapolis, Minn., where he is succeeded by **Allen G. Farley,** formerly administrative resident.

Evelyn Dye, R.N. — has been named director of nursing, South Florida Baptist Hospital, Plant City, Fla., succeeding **Minnie Lee West,** who resigned.

Mary Durham—is assistant director of nurses, Macon (Ga.) Hospital. She was formerly a head nurse, Crawford W. Long Memorial Hospital, Atlanta, Ga.

Rev. Norman O. Edwards—has been named superintendent, Bethany Deaconess Hospital, Brooklyn, N.Y., succeeding the **Rev. E. F. Steinkraus.**

Edward E. Erickson—is administrator, Beverly Hills (Calif.) Doctors Hospital.

D. Finke, M.D.—is administrator, Magma Copper Co. Hospital, Superior, Ariz.

O. L. Freeman—has been named administrator, Citizens' Hospital, Lumberton, Miss. He succeeds **William Knox.**

Ralph E. Gardner, M.D.—has been named administrator, Bertram (Texas) Hospital, succeeding **Jack G. Duffy, M.D.**

Sidney G. Garrett — has been named administrator, Latter Day Saints Hospital, Logan, Utah, where he has been business manager.

Anthony C. Garrick—has beep appointed administrator, Arizona State Tuberculosis Sanatarium, Tempe, succeeding **Henry Lesem,** who retired.

L. D. Garrison—is the new administrator, San Gabriel Valley (Calif.) Hospital.

Mrs. Marjorie Gerhardt, R. N.—has been named director of nurses, Hoemako Cooperative Hospital, Casa Grande, Ariz.

Mrs. Marlene Grout—is new supervisor, Curry General Hospital, Gold Beach, Ore., succeeding **Mrs. Dorothy Sauer,** who resigned because of illness. **Nina Stansell,** laboratory technician, shares the responsibility of the superintendent's position with Mrs. Grout.

R. J. Gully, M.D.—has resigned as superintendent, Cambridge (Minn.) State School and Hospital, to take a position at VA Hospital, Fort Meade, S.D.

Paul P. Halenda—is now administrator, Chelsea (Mass.) Memorial Hospital, succeeding **Mrs. Mabel V. Aronson, R. N.** He has been night administrator, Jackson Memorial Hospital, Miami, Fla.

Mrs. Clara Hang, R.N.—has been appointed administrator, Calexico (Calif.) Hospital.

Mrs. Ida Mae Hebert—is administrator, Beaumont (Tex.) Municipal Hospital, succeeding **Mrs. L. Holt Davis** who resigned because of ill health.

J. Gus Henderson—has resigned as administrator, John Peter Smith Hospital, Fort Worth, Tex., to accept a similar position at Pennsylvania Avenue Hospital, Fort Worth.

Edward H. Heyd—former administrator, Children's Hospital, Cincinnati, Ohio, is now administrator, Rowan Memorial Hospital, Salisbury, N.C., succeeding **Mrs. Lewis N. Miller.**

W. A. Hill—is administrator, as of Nov. 1, for the proposed new Community Memorial Hospital, Jefferson City, Mo. He was formerly administrator, Panola General Hospital, Carthage, Tex.

Guy T. Holcombe Sr., M.D.—has been elected chief-of-staff for the new Community Memorial Hospital to be located near Jennersville, Del.

Noble O. Hoover—superintendent for 29 years of Mennonite Hospital, Bloomington, Ill., has resigned. He is succeeded by **Theodore F. Kaap Jr.**, formerly credit manager, Presbyterian Hospital, Chicago.

William R. Howes—has accepted the position of administrator, St. Christopher's Hospital, Philadelphia. He was formerly administrator, Community Hospital of Evanston, Ill.

Robert D. Hume, Lt. Col.—succeeds **Robert G. Salasin, Lt. Col.**, as chief of surgical services, U.S. Army Hospital, Aberdeen Proving Ground, Md. He was formerly chief of obstetrics and gynecology. Col. Salasin left the Army to establish private surgical practice.

Mrs. Evelyne W. Hynes—is director of nurses, Riverside Hospital, Wilmington, Del.

Paul S. Jarrett—has been named administrator, West Valley Community Hospital, Encino, Calif.

David Johnson, M.D.—has been appointed pathologist, St. Louis (Mo.) City Hospital. Formerly he was associate pathologist, Rochester (N.Y.) General Hospital.

Howard Johnson—is now administrator, Petaluma (Calif.) District Hospital, now under construction.

E. Lynn Kelly—has been appointed administrator, Rio Hondo Memorial Hospital, Rivera, Calif.

Glen Keyes—has been appointed auditor, Sacred Heart Hospital, Medford, Ore.

Frank Latimer—has been appointed administrator, Castro County Hospital, Dimmitt, Tex., succeeding **R. H. Dorsett.**

Dewane Lindland—has been named administrator, Grinnell (Ia.) Community Hospital. He was formerly administrator, St. Anthony (Ida.) General Hospital.

Walter H. Mackie, Capt.—is the new executive officer, U.S. Army Hospital, Aberdeen Proving Ground, Md., succeeding **Robert B. Kerr, Lt. Col.** He previously served as adjutant. Col. Kerr has been transferred to the 68th Medical Group, Ft. Meade, Md.

E. L. McAmis, M.D.—superintendent, Natchez (Miss.) Charity Hospital, has resigned to resume private practice of medicine on a full-time basis.

Gorden M. Meade, M.D.—has been appointed clinical director, Miners Memorial Hospital Association, Washington, D.C. Since January he has been chief, clinical services, Williamson Memorial Medical Center.

Edward J. Mulroy, D.D.S.—has been named superintendent, Ashland (Pa.) State Hospital, succeeding **Barney W. Wentz.**

Joseph A. Oddis—has resigned as chief pharmacist, Western Pennsylvania Hospital, Pittsburgh, to become staff representative of the Council on Professional Practice, American Hospital Association, Chicago.

T. W. Olson—is assistant superintendent, Donald N. Sharp Memorial Hospital, San Diego, Calif.

Luis Carlos Prieto Jr., M.D.—has assumed duties as pathologist, St. Joseph Hospital, Memphis, Tenn., succeeding **William F. Hurteau, M.D.**, who resigned to join the department of pathology, Methodist Hospital, Indianapolis, Ind. Dr. Prieto was formerly assistant professor in pathology at the University of Tennessee College of Medicine.

Arthur Promisel—is administrator, Mid City Hospital, Los Angeles.

Philip G. Ramsey—has resigned as controller, Bradford (Pa.) Hospital.

Manda B. Roe—is administrator of the new McHenry (Ill.) Hospital. She was former administrator, Memorial Hospital, Woodstock, Ill.

John D. Rollins—has been appointed administrator, Ontonagon (Mich.) Memorial Hospital. He served his residency at St. Luke's Hospitals, Milwaukee, Wis.

John Scholz — is administrator, Washington Hospital, Los Angeles.

Thomas F. Sheehy Jr., M.D.—acting medical director, Firland Sanatorium, Seattle, Wash., has been appointed

(Continued on page 52)

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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

- Statute of Limitations
- What is Poison?
- Physician's Responsibility

A few weeks ago a higher court rendered a decision which clearly answers two important legal questions asked by an official of a hospital corporation, as follows: "How long can a patient delay in filing suit against a hospital to recover damages for an injury which he contends was caused by hospital employees? and what is the exact legal duty of hospital employees to prevent injuries to mentally ill patients?"

For illustrations, in Marks v. St. Francis Hospital, 294 Pac. (2d) 258, the testimony showed facts, as follows: The St. Francis Hospital operates a hospital for the care of mentally and physically ill persons who require hospital service. In October, 1952, the St. Francis Hospital accepted as a patient, Mary Marks, who was then in need of hospitalization due to her mental and physical condition. She was placed in the hospital under the direction of G. O. Street, M.D., a psychiatric specialist.

Mary Marks died from injuries sustained when she was allowed to leave the hospital unattended on November 10, 1952. A suit was filed by relatives of Marks against the hospital for damages on the grounds that the hospital officials and employees were negligent in failing to provide customary and physical supervision and care for the type of mental and physical illness from which she was suffering. This suit was effectually filed in January 1955. A state law provides that suits of this kind must be filed within 2 years from the date the injuries were sustained by the patient. In view of this state law, the higher court refused to hold the St. Francis Hospital liable in damages for death of Marks, and said:

"Not until after the bar of the statute of limitations had fallen was the amendment filed. That was too late and we need not discuss whether or not it stated a cause of action."

With respect to the legal duty of a hospital corporation to normally safeguard Marks against injuries, this court explained that the extent and character of the care that a hospital owes its patients depends on the circumstances of each particular case. A private hospital owes its patients the duty of protection, and must exercise such reasonable care toward a patient as his known condition may require. The measure of duty of a hospital is to exercise that degree of care, skill, and diligence used by hospitals generally in that community.

A hospital is liable for want of ordinary care, whether from incompetency of a nurse or failure in duty by a fully qualified nurse. Also, the court explained that the duty of care imposed on a hospital extends to safeguarding the patient from dangers due to mental incapacity. On the other hand, a private hospital is not an insurer of a patient's safety, and its employees are not required to guard against or take measures to avert that which a reasonable person under the circumstances would not anticipate as likely to happen.

In other words, with respect to the duty of hospital officials and employees to safeguard mentally ill patients, it is clear that a hospital must exercise toward such patient such reasonable care as his known condition may require. It follows that the extent and character of the duty owed by the hospital will depend on the circumstances of each case.

See 26 Am. Jur. p 595, where the rule is thus stated: "The degree of care exacted of private institutions toward their patients is such reasonable care and attention for their safety as their mental and physical condition, if known, may require, and should be in proportion to the physical or mental ailments of the patient, rendering him unable to look after his own safety."

WHAT IS POISON?

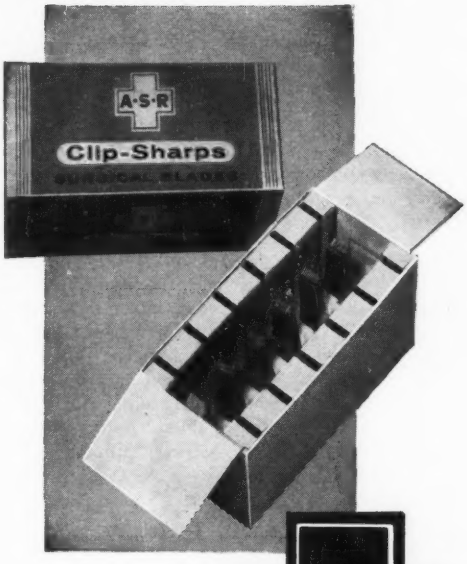
Recently a higher court rendered an important decision which answers a legal question submitted by an official of a large hospital corporation. He wrote, as follows: "Our hospital is having legal difficulties relative to the sale of drugs which are on the dividing line between poisons and ordinary proprietary medicines. For example, in your opinion, is a disinfectant a poison? Some manufacturers clearly print on the cans and containers of their pharmaceutical products the word "poison." Does this mean that such products are within the scope of state laws which specify methods of sale and limitations of the sale and distribution of such products?"

A few weeks ago a higher court held that disinfecting poisons are not within the scope of state laws which require that only registered pharmacists sell and dispense poisons, provided such products are in the original packages and labeled as required by the Federal Food, Drug and Cosmetic Act.

For instance, in State v. Cramer Drug Company, 121 N.E. (2d) 85, the testimony showed that a state law prohibits the sale of poisons in drug stores not having on duty a registered pharmacist. The law also provides that it shall not apply to "proprietary" medicines which are sold in original packages.

A hospital drug store did not have a registered pharmacist on duty when a clerk sold to a customer

(Continued on page 48)



now! quick, easy blade sterilization with

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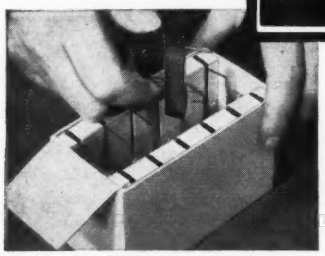
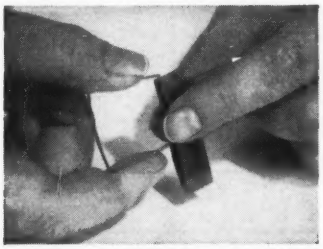
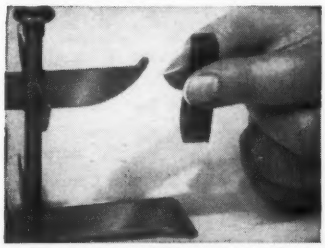
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

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REVIEW OF HOSPITAL LAWSUITS

(Continued from page 46)

a product in the original package known as Lysol. This is a pharmaceutical product which is sold in the original package to be used as an antiseptic douche and for cuts, scratches, and lacerations, ringworm of the foot, burns, scalds, bee stings and nonvenomous insect bites, as well as for disinfecting sick rooms and all general housecleaning.

It is interesting to observe that the higher court refused to convict the drug company because its clerk sold Lysol in the original package, saying:

"Without pursuing the question further, it is our judgment that the product, "Lysol," is a proprietary medicine and that, even though it is a poison, its sale by a retail dealer excepted from the application of Section 12706. In our judgment, the conviction of the defendant (Cramer Drug Company) on the charge of selling a poison is not proven by the evidence."

The court said further that whether any drug is a proprietary medicine presents difficulty in all such cases. The court said:

"The product, 'Lysol' has many uses, which properly bring it within the classification of a proprietary medicine."

The higher court rendered the above verdict, notwithstanding the fact that the State Board of Pharmacy ruled that Lysol is not a proprietary medicine.

For comparison, see State Board of Pharmacy v. Matthews, 197 N. Y. 353. In this case a New York court held that tincture of iodine, tincture of arnica and spirits of camphor, though commonly used as cosmetic remedies, are nevertheless medicines within the New York pharmacy law, prohibiting, under penalties, the sale of medicines or poisons except in the presence and under the supervision of licensed pharmacist.

Therefore, it is quite apparent that whether a hospital must comply with a state law, controlling the sale of drugs, depends entirely upon the legal interpretation by the higher court of the laws of this particular state.

HOSPITAL PHYSICIAN DIRECTS NURSE

A reader asked this question: "If a hospital nurse sustains injuries directly resulting from following instructions of the hospital's physician, can the nurse get damages from the hospital for her injuries?"

According to a late higher court decision the answer is yes since the courts hold that, under certain circumstances, the hospital's physician is expected by law to personally investigate an apparently dangerous patient.

For illustration, in Hudson v. Blanchard, 294 pac. (2d) 554, the testimony as presented disclosed rather unusual facts, as follows: A nurse sued her hospital employer for heavy damages for personal injuries sustained as a result of having been thrown violently against a door frame by a patient in the hospital. Further testimony showed that one night an alcoholic was sufficiently recovered to go about the hospital. For some reason he became upset, was threatening to leave the hospital, and his conduct was such as to cause considerable disturbance.

The nurse testified that the patient was unsteady on his feet, and smelled of whiskey. She called Dr. Hudson, the hospital physician, told him the situation, and was advised to give the patient an aspirin and put him to bed. At that time the patient displayed physical violence to such an extent that the nurse was unable to handle him. She again telephoned Dr. Hudson, who inquired whether she was able to handle her job, and she told him she could not handle the patient, but again was told to put him to bed.

Following this call, she was with the patient in his room when he seized her right arm and threw her so that her shoulder and neck struck the corner or door frame. Dr. Hudson came to the hospital, following another call, gave the patient a sedative to quiet him, and then rubbed the nurse's neck and shoulder. When she went off duty about 8 A.M. she went home and stayed for 14 months, suffering from the injuries she sustained when the alcoholic threw her against the door frame.

Although some testimony was given in favor of the hospital that the nurse had previously suffered injuries in an automobile accident, the jury held that the hospital must pay her $5,000 damages. The higher court approved the verdict.

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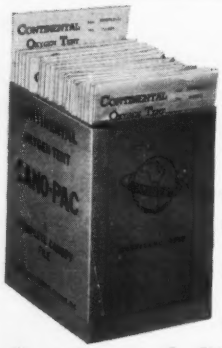

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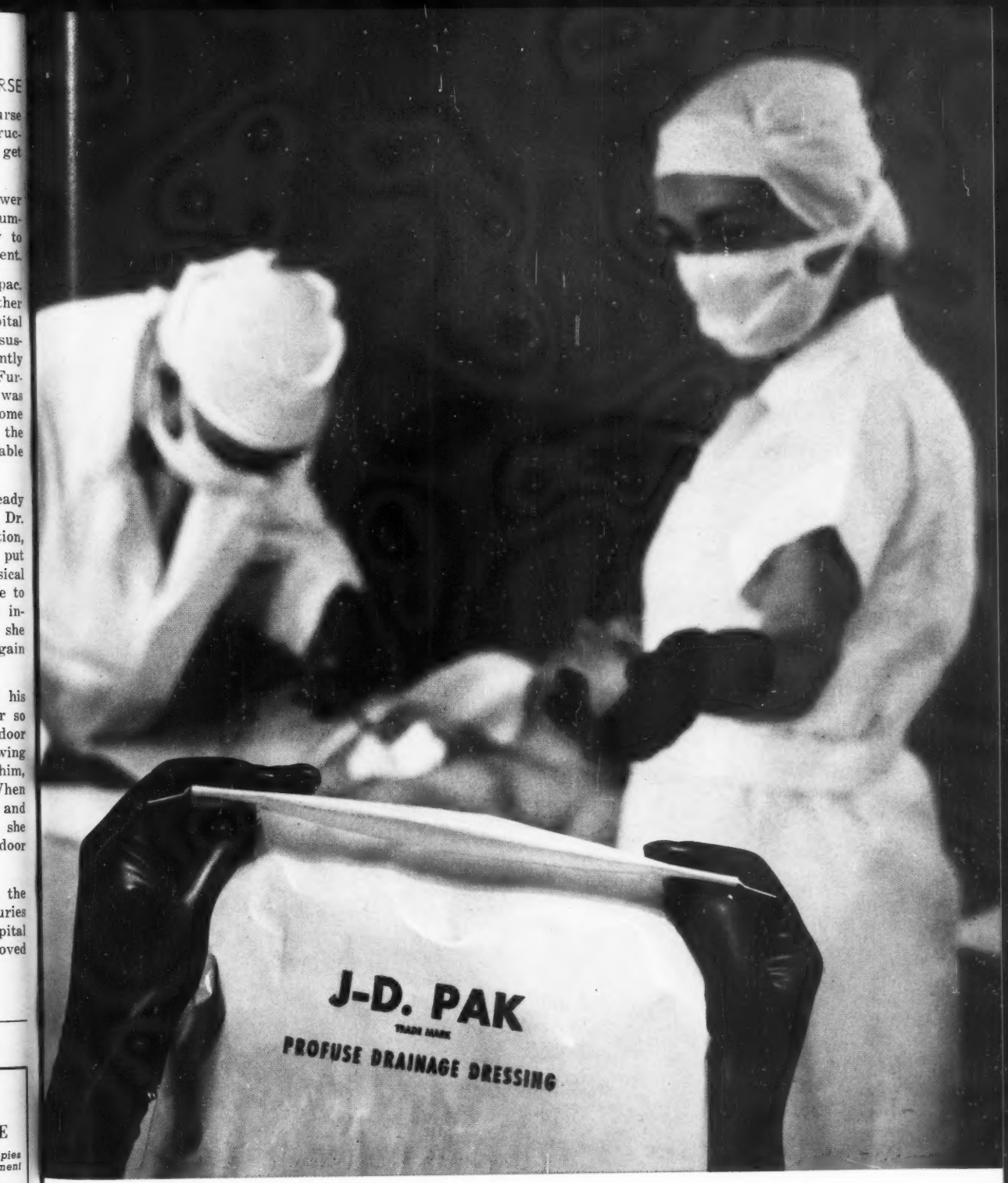

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TRADE TOPICS...

Above: Propper Manufacturing Co., Inc., Long Island, N.Y., sales department seated after a recent sales meeting (l. to r.): Al Barberich, Jim Donnelly, Ed Prescott, Frank Ricker and Bill Gleason. Standing (l. to r.): Kal Gladstone, Art Wood, sales manager; Al Numan, and Ed Cantor, director of sales.

Anker Appointed Hospital Division Sales Manager

Theodore G. Anker has been appointed sales manager, hospital equipment division, S. Blickman, Inc., Weehawken, N. J. He will be involved with sales and service of hospital casework and scientific laboratory furniture, portable hospital furniture, and food conveyors.

Formerly he was general sales manager in the laboratory furniture and casework manufacturing field.

C. R. Bard Appoints New Representative

John Van Houten Berdan has been appointed by C. R. Bard, Inc. to represent the company in New Jersey and New York outside of New York City. Formerly he was sales representative, National Carbon division, Union Carbon and Carbide Corp.

Abbott Laboratories Again Expands

Abbott Laboratories, North Chicago, Ill., has announced a half-million-dollar contract for a chemical manufacturing building, which will increase the capacity of the bulk chemical plant by 20 percent.

Construction is scheduled to begin immediately and will be completed by April, 1957.

Aerojet-General Nucleonics Moves to San Ramon Plant

Aerojet-General Nucleonics, the newly established subsidiary, Aerojet-General Corp., has moved into its new plant and engineering facilities, in San Ramon, Calif.

The facilities include administration and sales offices, engineering, design, and research laboratories, and a production area. They produce AGN-201, the world's first mass produced reactor.

News Briefs

Charles H. Bronson—has been appointed development manager, industrial division, Lever Brothers Co., New York City. Formerly he was market development manager, Tennessee Corp.

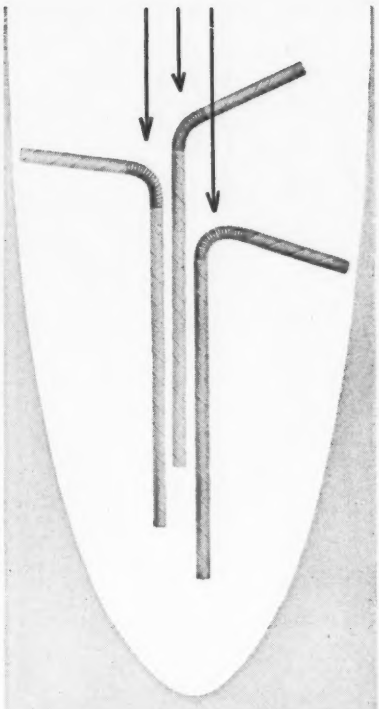
* * *

Gilbert K. Petri—has been appointed southwest territory manager, hospital division, American Safety Razor Corp. He has been assigned to the states of Texas, Louisiana, Oklahoma, Arkansas and Mississippi.

* * *

William J. Briggs—has been appointed western regional sales manager, George A. Breon & Co. Formerly he was assistant sales manager.

(Continued on next page)



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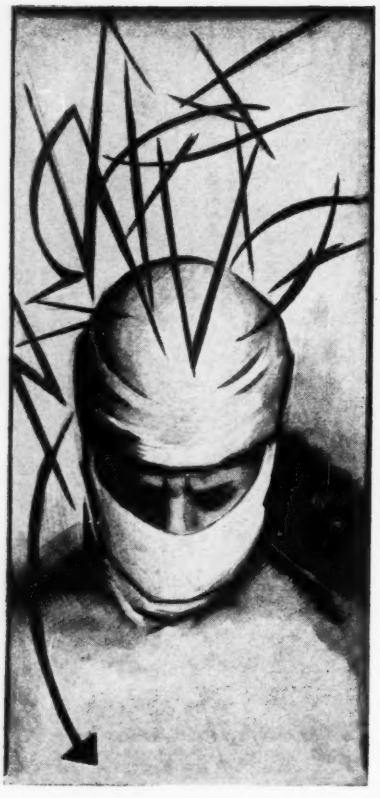

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Left: J. G. Dyett (l.), Hard Mfg. Co. and new president, Hospital Industries Association, is congratulated by HIA vice-presidents R. F. Simons, Ethicon, Inc., and Ray Hausted (r.), Hausted Mfg. Co.

Upjohn Company Opens Cincinnati Branch

V. R. Facciuto has been named sales manager, Cincinnati branch, The UpJohn Co.

The new branch, which contains both warehouse and office facilities, will serve a five-state area including parts of Ohio, Indiana, Kentucky, Virginia, and West Virginia.

Breuer Electric Mfg. Co. Names Sales Manager

Robert L. Kline has been appointed general sales manager, Breuer Electric Mfg. Co. Formerly he was regional sales manager for the west coast and the western provinces of Canada. He will supervise all sales for the company's complete line of heavy-duty and noiseless vacuum cleaners, floor-scrubbing machines, portable electric blowers, and dust-collectors.

New Marketing Manager For Ritter Company

Kurt V. Vogt has been appointed marketing manager, Ritter Co. He was formerly manager of advertising and sales promotion.

Parke, Davis & Co. Marks Anniversary

Parke, Davis & Co. celebrated its 90th anniversary in October.

The company now has 28 branches, depots, or manufacturing laboratories in 18 areas of the world. Major distributors are located in practically all other countries outside the Iron Curtain.

Will Ross, Inc. Announces Appointments

Jack D. Bryson and Raymond E. Connelly have been elected to assistant vice-presidents for sales, Will Ross, Inc. Milwaukee, Wis. Wilfred J. Polzin is assistant vice-president for purchasing.

Will Ross is a national manufacturer and distributor of hospital supplies and equipment.

J & J Appoints Lierman Hospital Division Assistant

James D. Lierman has been named assistant director, Johnson & Johnson's hospital division. Formerly he was director of merchandising.

The hospital division has been expanded because of the increasing number of new products.

* * *

Harry C. Phibbs Advertising Co.—has been appointed to service the advertising account, parenteral products division, Mead Johnson & Co. Evansville, Ind.

(Continued on page 56)

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(Continued from page 45)

permanently to that position.

John D. Rollins—has been appointed administrator, Ontonagon (Mich.) Memorial Hospital. He served his residency at St. Luke's Hospital, Milwaukee, Wis.

Murray Shell—has been appointed administrator, Metropolitan Hospital, Los Angeles.

Sister Cuniberta—director of the nursing school, St. Anthony's Hospital, Pendleton, Ore., is going to St. Elizabeth Hospital, Baker, Ore., as administrator. She succeeds **Sister Mary Lawrence,** now administrator, St. Anthony's Hospital.

Sister M. John Chrysoston—is succeeding **Sister M. Theodore** as administrator, San Antonio Hospital, Kenton, Ohio. **Sister Mary George** has been assigned as assistant administrator.

Sister Mary Lawrence—has been assigned as administrator, St. Anthony's Hospital, Pendleton, Ore., succeeding **Sister Mary Melchior.**

Sister Mary St. Kevin—has been assigned as administrator, St. Francis Hospital, Wilmington, Del., succeeding **Sister Mary Euphrasia.** She has been administrator, St. Patrick's Franciscan Hospital, Cork, Ireland. Sister M. Euphrasia remains in Wilmington to direct the building of a hospital annex and clinic.

Sister Rozetta—succeeds **Sister Marcella** as administrator, Mercy Hospital, Liberty, Tex. Sister Marcella has been transferred to St. Jude Hospital, Brenham, Tex.

Mrs. Mary E. Smythe—is the new head nurse at Henry County General Hospital, Paris, Tenn., succeeding **Mrs. Frances England.**

Peter Solyom Jr.—assistant chief pharmacist, University of Chicago Clinics, Chicago, is now chief pharmacist.

Roy C. Stephenson—was appointed administrator, Lowell (Mass.) General Hospital. He succeeds **Paul J. Spencer.**

Catherine M. Sullivan—has been appointed assistant chief nurse, Federal Civil Defense Administration Health Office, National Headquarters, Battle Creek, Mich.

Anne B. Vonovick—has resigned as administrator, Riverside Community Memorial Hospital, Oshkosh, Wis., to accept the position of administrator, Memorial Hospital, Manitowoc, Wis.

Patricia Wandler—is now administrator, Lompoc (Calif.) Hospital District.

Sally Wanzer—is assistant medical record librarian, St. Luke's Hospital, Chicago.

G. S. Waraich, M.D.—clinical director, State Hospital Number One, Fulton, Mo., has been transferred to a similar position, State Hospital Number Two, St. Joseph, Mo.

Lester H. Wehner — succeeds **Charles A. Okey** as administrator, Lutheran Hospital, Omaha, Neb. He has been assistant administrator.

A. J. Williamson—has resigned as administrator, Grafton (W.Va.) City Hospital, to become administrator at Community Hospital, Circleville, Ohio.

David L. Winebrenner—is administrative assistant in charge of evening service, Chicago Wesley Memorial Hospital, Chicago.

J. Robert Young Jr.—has joined the staff of Macon (Ga.) Hospital as pharmacist.

Anna L. Zimmerman, R.N.—director of nursing service, Aultman Hospital, Canton, O. has resigned to return to school for a master's degree.

VA Appointments

Bernard M. Anderman, Ed.D.—chief audiologist, VA regional office, New York City, has been appointed chief of audiology and speech correction, VA department of medicine and surgery, Washington, D.C. He succeeds Kenneth O. Johnson, M.D., who left VA to become director, San Francisco Hearing and Speech Center.

John J. Cox—chief, postgraduate and inservice training division, VA department of medicine and surgery, Washington, D.C., has been assigned as special assistant to the manager, Va Hospital, Boston.

George D. Frye—has been appointed chief of occupational therapy, physical medicine and rehabilitation service, department of medicine and surgery, VA office, Washington, D.C. He was formerly chief of occupational therapy, VA Hospital, Knoxville, Ia.

John L. Haskins, M.D.—director of professional service, Brentwood Neuropsychiatric VA Hospital, West Los Angeles, has been transferred to St. Paul, Minn., as chief of psychiatry and neurology, VA area office.

Horace D. Smith, M.D.—is manager, VA Hospital, Omaha, Neb., succeeding Clifford C. Woods, M.D. He was formerly director of professional services, VA Hospital, Long Beach, Calif.

Donald D. Van Meter—has been appointed assistant manager, Kennedy VA Hospital, Memphis, Tenn., succeeding Herbert A. Chase, who has been transferred to VA Hospital, New York City. He was formerly assistant manager, VA Hospital, Richmond, VA.

VA Nursing Appointments

Beatrice Cookson—has been assigned as assistant chief, nursing education, Batavia VA Hospital, New York. She was formerly a supervisor there.

Eleanore Cusick — is assistant chief, nursing service, VA Hospital, Madison, Wis. She was formerly supervisor, VA Hospital, Wood, Wis.

Regina Eck—has been appointed chief, nursing service, Cheyenne VA Hospital, Wyo. She had been assistant chief, VA Hospital, Clarksburg, W. Va.

Helen Ellis—is chief, nursing service, Roseburg VA Hospital, Ore. She formerly held a similar position at Waco, Tex.

Mary Ellis—has been named assistant chief, nursing education, Fresno (Calif.) VA Hospital. She had held a similar position at Cheyenne, Wyo.

Kathleen Kehoe—is an assistant chief, nursing service, VA Medical Teaching Group Hospital, Memphis, Tenn., where she was formerly a supervisor.

Ruth Kruse—has been appointed assistant chief, nursing education, Cincinnati (Ohio) VA Hospital, where she was formerly an instructor.

Elizabeth MacDiarmid—is chief, nursing unit, Hartford (Conn.) regional office. She was formerly at Newark, N.J.

Ernest Newcomb—has been assigned as assistant chief, nursing service, Ft. Lyon (Col.) VA Hospital. He was formerly a supervisor, VA Hospital, Syracuse, N.Y.

Grace Porterfield — is assistant chief, nursing service, VA Hospital, Tuscaloosa, Ala. She had been a supervisor, Leech Farm Road VA Hospital, Pittsburgh, Pa.

Edith Schultheis—has been named assistant chief, nursing education, VA Hospital, Dublin, Ga., where she was formerly acting assistant chief.

Alfred Towner—is chief, nursing service, VA Hospital, Sheridan, Wyo. He was assistant chief, nursing education, Jefferson Barracks, Mo.

Deaths

James Austin Ball,—81, professor emeritus of dermatology and medicine, Medical College of South Carolina, died Sept. 16. He had served on the staffs of Willard, Contagious Diseases, and St. Mark's Hospitals, and Kings County Hospital Center, New York City.

J. Wallace Beil, M.D.—79, died Sept. 22. He had served on the staffs, St. Joseph and Kansas City (Mo.) General Hospitals. He also performed all nose and throat surgery for St. Anthony's Baby Home and St. Joseph Orphanage, Kansas City, Mo.

Albert A. Bengelsdorf, M.D.—65, specialist in metabolism and endocrinology, died Sept. 13. He was affiliated with Beth Israel, Presbyterian and St. Michael's Hospitals, Newark, N. J., and was a former head of the Beth Israel medical clinic.

Samuel Sylvester Berger, M.D.—72, gastroenterologist, died Sept. 18. He was a former chief of medicine, Mount Sinai Hospital, Cleveland, O.

Henry Borow, M.D.—51, one of four founders, Bound Brook (N. J.) Hospital, died Sept. 9. He was an authority on congenital heart disease in children.

J. R. Bunch, M.D.—former superintendent, State Hospital Number One, Fulton, Mo., died Sept. 29. He had also been assistant superintendent at State Hospital Number Two, St. Joseph, Mo.

John Charles Callahan—65, administrator, Tampa (Fla.) Negro Hospital, died Sept. 18. He was formerly assistant administrator, Tampa Municipal Hospital.

William Clinton Calvert, M.D.—53, died Sept. 29. He was associated with East Orange (N. J.) General, Montclair (N. J.) Community and Orange (N. J.) Memorial Hospitals, and with the Kessler Institute for Rehabilitation, West Orange, N. J.

Lucien B. Dana—42, administrator, Knickerbocker Hospital, New York City, died Sept. 14.

Mortimer Danzer, M.D. — 52, Brooklyn (N.Y.) blood specialist and former president, Brooklyn Society for Oral Diagnosis, died Sept. 5.

William Richard Dear, Brig. Gen.—72, former commanding general, Northington General Hospital, Tuscaloosa, Ala., died Sept. 7.

William Alexander Newman Dorland, M.D.—92, died Sept. 11. He had been professor of obstetrics, Loyola University, Chicago, and professor of gynecology, Illinois Post-Graduate Medical College, Chicago. He compiled the American Illustrated Medical Dictionary.

B. Landis Elliott, M.D.—65, neurologist and psychiatrist, died Sept. 8. He was chief of staff, St. Joseph Hospital, and head of the psychiatric department, St. Mary's Hospital, Kansas City, Mo. and was a staff member of seven other hospitals, and on the faculty, University of Kansas Medical Center.

George W. Ely, M.D.—84, one of the founders, Doctor's Hospital, Pittsburgh, died Sept. 17. He had served on the staffs, St. Francis General and Pittsburgh Hospitals.

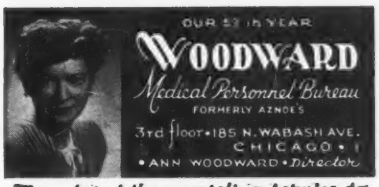
W. W. Fowler, M.D.—84, editor, Dallas (Tex.) Medical Journal, died Sept. 10. He was a pioneer in medical specialization.

John Gould Gardner, M.D.—74, former president, Mississippi Hospital Association, died recently. He founded the Columbia (Miss.) Clinic and Hospital.

W. H. Glafke, M.D.—70, died recently. He was associate physician in gastroenterology, St. Luke's Hospital, and attending gastroenterologist, Women's Hospital, New York City.

Ralf Hanks, M.D.—61, former superintendent, State Hospital Number Two, St. Joseph, Mo., died Sept. 25. Dr. Hanks also served as superintendent at State Hospital Number One, Fulton, Mo., and at State Hospital Number Three, Nevada, Mo.

John W. Heim, M.D.—75, physician and anesthesiologist, died Sept. 25.



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ADMINISTRATOR: BBA; MBA (hosp admin) pending; year's hosp res; 1 year, Ass't Adm, 300 bd tch'g hosp; 1 year, Ass't Sup't & Comptroller, 500 bd city hqsp; 2 yrs, dir 500 bed city hosp; seeks return to vol hosp 200 bds, up; or clinic mgr, grp, 10 men or larger; middle 30's; nominee ACHA.

ANESTHESIOLOGIST: 3 yrs, priv pract, anes; 2 yrs, assoc anes, tch'g hosp; now ready for own dept; any locality; Diplomate.

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He was past president of the staffs, Jewish Hospital and the old Deaconess Hospital, Louisville, Ky.

James A. Henderson, M.D.—48, died Sept. 2. He was on the staffs, St. Mary's and Blessing Hospitals, Quincy, Ill. and was nationally known for his research in new products and drugs.

W. Harriman Jones, M.D.—80, founder of the Harriman Jones Clinic

(Continued on next page)

and Hospital, Long Beach, Calif., died June 17. At one time he was chief of staff, Seaside Memorial Hospital, Long Beach.

Justin Ford Kimball, M.D.—84, credited with being the founder of Blue Cross hospital group insurance, died Oct.7.

Charles W. Layne, M.D.—55, died Sept. 21. Attending physican at St. Luke's Hospital, Newburgh, N. Y., where he was former chief of staff, he was on the consulting staffs, Harlem Valley State Hospital, Wingdale, N.Y.; Matteawan State Hospital and Craig House, Beacon, N.Y.; and St. Anthony's Hospital, Warwick, N.Y.

David Russell Lyman, M.D.—authority on detection and treatment of tuberculosis, died Oct. 15 at 81. Medical superintendent at Gaylord Farm Sanatorium, Wallingford, Conn., he was a founder of the National Tuberculosis Association.

Ben Markowitz, M.D.—60, physician, surgeon and pathologist, died Sept. 17. He was pathologist for Bloomington, Normal and Lincoln (Ill.) hospitals.

Charles H. Nammack, M.D.—68, director, fourth medical division, Bellevue Hospital, New York City, died recently. He was on the staff, Polyclinic Hospital, and consultant to Misericordia and University Hospitals, New York City.

Alexander Nicoll, M.D.—director of the first surgical division, Fordham Hospital, New York City, died Sept. 24. He was consultant surgeon there and at St. Elizabeth's Hospital, where he also had been chief of the surgical staff. He had been director of surgery, St. Francis Hospital, New York City, and consultant, in surgery, Mother Cabrini Memorial Hospital, New York City, and Central Suffolk Hospital, Riverhead, N.Y.

I. W. Potter, M.D.—87, one of the world's most famous obstetricians, died Sept. 17. He delivered more than 25,000 babies, and was credited with perfecting the technic of version. Dr. Potter had been on the staff, Deaconess Hospital, Buffalo, and was associated with Edward J. Meyer Memorial, Lafayette General, Buffalo Columbus, and Salvation Army Hospitals, Buffalo.

Henry Barnard Safford, M.D.—73, author of the "Tell Me, Doctor" column in the Ladies Home Journal, died Sept. 16. He had been chief of staff for gynecology and obstetrics, Flower and Fifth Avenue Hospitals, New York City, and the Metropolitan Hospital on Welfare Island.

Hans S. Schiffbauer, M.D.—73, Los Angeles chest surgeon, associated with California Lutheran Hospital, Los Angeles, died Sept. 17.

William A. Teveluwe, M.D.—former president, St. Mary Hospital, Cincinnati, O., died Sept.17.

George Holten Trough, M.D.—66, former chief of staff, Fairmont (W.Va.) Hospital, died Sept. 19.

Frank Vernon, M.D.—46, surgeon on the staffs, United Mine Workers and Methodist Hospitals, Pikeville, Ky., died recently.

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Rehabilitation Award Goes To VA Physician

The John E. Davis plaque, highest honor in the physical medicine and rehabilitation service, has been awarded to Louis B. Newman, M.D., chief, physical medicine and rehabilitation, VA Research Hospital, Chicago.

The award, for "distinguished leadership and outstanding service," was presented by the Association for Physical and Mental Rehabilitation.

Dr. Newman has developed several devices to assist in the rehabilitation process, including the Thermo-Flo machine for pelvic heating and the Myometer for measuring muscle strength. He is also the author of numerous articles and textbook contributions.

Hospital Care Committee Set Up by U.S. Health Dept.

An advisory committee to develop methods for improving hospital care and reducing costs has been set up by the United States Health, Education and Welfare Department.

Russell Nelson, M.D., director, Johns Hopkins Hospital, Baltimore, will be chairman, advisory committee on hospital facilities and services.

The committee will review information on current practices and facilities. It will develop tentative recommendations for the design and organization of hospital units more closely related to the specific needs of patients.

Also the committee will consider possibilities for developing hospital units in which patients could provide more services for themselves.

Other members of the committee are: Robert Elman, M.D., school of medicine, Washington University, St. Louis; Ray E. Brown, retiring president, AHA; Charles G. Roswell, hospital accountant; Ruth Sleeper, director, school of nursing, Massachusetts General Hospital; and Marion J. Wright, director, Jennings Memorial Hospital, Detroit.

Maine Hospital Changes Name

The name of the Presque Isle (Me.) Hospital was changed on July 6 to the Arthur R. Gould Memorial Hospital. The change was made by the corporate board.

Recreation Group Undertakes Hospital Survey

Determining the extent to which the 9,000 hospitals in the United States provide recreation programs under professional leadership is the aim of a study by the National Recreation Association.

Data will be collected on the number of professional recreation workers now in the hospital field, their educational background, and their relationship to the hospital administration.

The study will also show the scope of recreation programs now provided in hospitals.

A goal of the project is to obtain needed information to plan for college courses in hospital recreation. More than 65 colleges now offer major courses in recreation leadership.

It is also expected that the study will help define the role of recreation for patients.

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TRADE TOPICS
Continued from page 50

V. Mueller & Co. Opens Los Angeles Branch

V. Mueller & Co. has opened a new retail branch store at 747 S. La Brea, Los Angeles.

This branch will maintain a comprehensive line of standard and special surgical instruments, in addition to supplies and equipment.

Hal Markham will manage the California branch.

Don Baxter Company Elects Chairman

Emery S. Beardsley has been elected chairman, board of directors, Don Baxter, Inc., Glendale, Calif.

Mr. Beardsley has been president of Don Baxter, Inc. for the past 20 years. The company is a wholly-owned subsidiary of American Hospital Supply Corp., Evanston, Ill.

Keith P. Pattengill, formerly executive vice president was elected president, Don Baxter, Inc.

Beltone Hearing Aid Co. Names Singer Director

Ellis E. Singer has been appointed director, national program for cooperating with leading hospitals and schools, Beltone Hearing Aid Co.

He will act as a liaison between the company's distributor organization and professional institutions and groups. Formerly he was an audiologist, VA audiology clinic, New York regional office.

Mead Johnson Awards $50,000 for Fellowships

The Mead Johnson & Co. Foundation, Inc., Evansville, Ind. has given $50,000 to the American Foundation for Pharmaceutical Education to establish a fellowship to be awarded each year to a graduate student selected by the AFPE board of grants

The awards will be known as the E. Mead Johnson Memorial Fellowships.

John S. Ruggiero, the first fellowship recipient, is working on his Ph.D. at the University of Connecticut.

News Briefs

Cresap, McCormick and Paget management consultants recently opened an office at 235 Montgomery Street, San Francisco, Calif.

* * *

Richard J. Brown—has been appointed chief engineer, Crescent Metal Products, Inc. He will be in charge of all engineering functions, research and development on the Cres-Cor line of aluminum food service equipment.

* * *

George P. Pilling & Son Co.—announce the opening of an office and display room in New York City located at 4 West 56th Street. Mr. James P. Kelly will be in charge of the office.

* * *

Troy Laundry Machinery—has opened a new Boston office at 30 Huntington Avenue, room 304. I.N. Johnson will supervise the operation of the office.

* * *

Maurice McCormack—has been promoted to assistant sales manager, Schenley Laboratories, Inc. Formerly he was assistant to the sales vice president. * * *

James M. Cotter—has been appointed vice president, Ohio Chemical & Surgical Equipment Co. Formerly he was controller.

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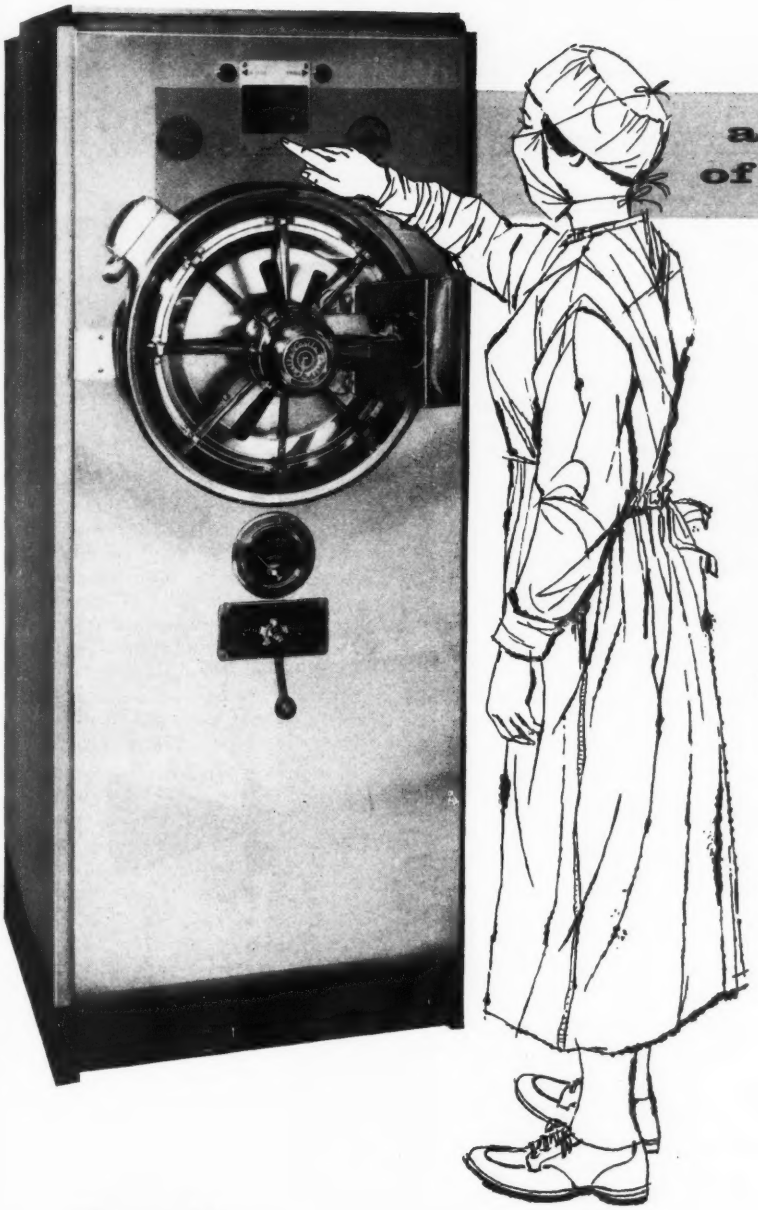

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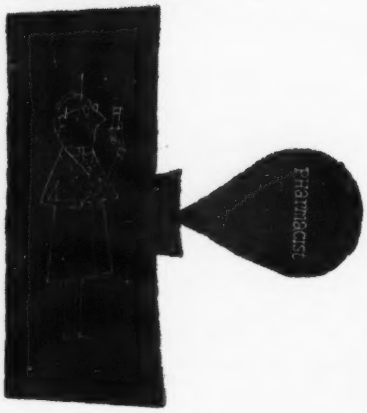

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Play Ladies Give Children Little Extra Something at Pittsburgh Children's Hospital

Pediatrics

Youngsters at Pittsburgh Children's Hospital get something extra in addition to excellent treatment and nursing care—there is always someone or something on hand for them to play with! An excellent recreation program assures each child in this 225-bed hospital the love and attention needed to hasten his recovery.

The hospital's recreation program, under the direction of Marcella Feinauer, R.N., director of nursing service, and a full time recreation director, Baylee Friedman Gordon, has made every one in the hospital aware of the importance of play in caring for children. Doctors, nurses and other members of the hospital staff use "play therapy" whenever possible. The main part of the program is carried on by volunteers, Red Cross gray ladies and special "play nurses" who spend their time exclusively in entertaining the children.

Affiliating nurses from 10 different hospitals in the Pittsburgh area spend three months of their training at Children's Hospital. One week of that training is devoted to play. The students take off their uniforms, don blue smocks and spend the week doing very much what gray ladies and volunteers do—playing games, reading stories, and working with the children on special projects and parties.

There are appproximately 12 play nurses on duty each week. Before starting their assignment they attend a lecture on the theory of play; for the most part, however, they learn by doing. Miss Feinauer believes that each nurse in a pediatric unit should learn to utilize the many opportunities available for play while doing routine tasks. Nurses are taught to play finger games while dressing toddlers; they tell stories or play word games while giving the youngsters a bath. They always have a smile and a cheerful word for the children.

There is usually a play nurse or gray lady on hand to greet a new patient and one to stay with the child when his parents go home. The play nurses see that babies are taken out of their cribs as much as possible, and either rocked or put in play pens or baby tendas. Ambulatory patients go for walks with a play nurse along and if there is an opportunity to watch TV or listen to the radio the students usually supervise. They also work closely with the hospital's full-time school teacher in carrying out special art and handicraft programs.

Most recreational activities are centered in the care area itself. Toys, games and stuffed animals are dis-

(Continued on next page)

Below: A game of bingo keeps these children busy. Playing together is encouraged, even if it means rumpling beds or moving chairs or furniture. Entertaining the children comes first; neatness and order are of secondary importance.

Left: Birthdays are never neglected at Children's Hospital. The youngsters shown here blowing out the candles on their cake will get presents too. There is a birthday party every month.

PEDIATRICS Continued

tributed lavishly; each child always has at least one plaything close at hand. Even in the physical therapy department, mobiles and stuffed animals predominate. Toys are hidden in the sand box in the exercise room and float toys are used in the tub-room. In the dental office Chippey, the puppet, advises children on mouth care. Toys are utilized in almost every department.

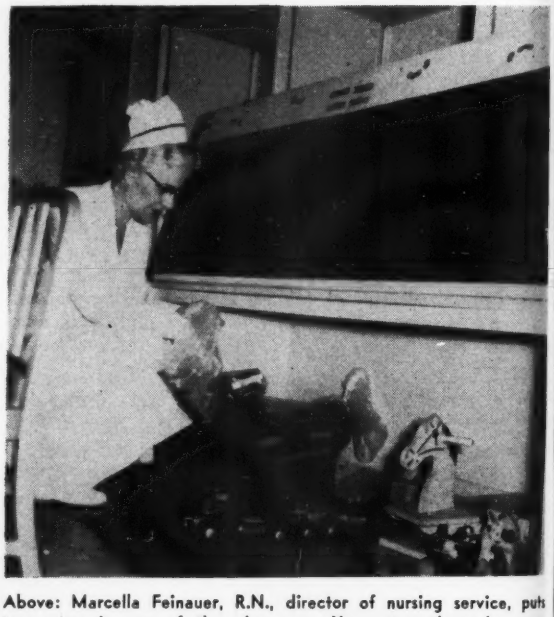
Books from the hospital's circulating library keep many children happy, and there is a play nurse or gray lady available to read stories. If a child wishes to play games or work on cut-outs with another patient, someone will push their beds together so they can. No one objects to disrupting a room; keeping the children entertained is the important thing.

Whenever possible, patients do get out of bed. Each ward has a special playroom for ambulatory children—a bright, cheerfully decorated room filled with games and toys. Special cabinets along one wall hold toys that the children can get at by pulling open special doors with blackboards on the inside. Above these cabinets are others that lock; special materials are kept here where only play nurses or volunteers can get at them.

Little tables and chairs are scattered around the room and the children are free to hold tea parties, color, paste or play together as they please. Every patient is dressed in regular clothes if at all possible, so that he will feel as much at home as possible in the hospital surroundings. Volunteers make most of the girls' dresses, using a variety of materials so they will not resemble uniforms.

In addition to regular activities, patients see movies twice a week—one new picture followed by an educational film. Celebrities frequently visit the hospital also and special preparations are made for their arrival. These visitors usually perform, give autographs and take time to greet as many children as possible.

Once each month a birthday party is held. Each child who has had a birthday during the month celebrates it at this time. There are always presents and a huge birthday cake. Each party is built around a central theme; for example, there is a May Day party for the May birthdays, a mock wedding party in June, a back-to-school party in September.



Above: Marcella Feinauer, R.N., director of nursing service, puts toys away in one of the playrooms. Youngsters themselves can take out and put away toys in these handy cabinets. Note the blackboards on the inside of the doors and the plastic bags, which are used for storing blocks and other small toys.

There are endless possibilities on having the children participate with the dietitian in menu planning. An example is the annual porch picnic at the end of the school year. The picnic lunch is the result of the children's suggestions and all their favorite foods are there.

Holidays are always celebrated at Children's Hospital, with the biggest party of all at Christmas time. Plans for the Christmas party are made weeks in advance. Gifts pour in for the youngsters. Many of the toys that arrive at Christmas time are kept in reserve for use throughout the year.

Although Pittsburgh Children's Hospital is a large hospital with many volunteers and more facilities than the average, many of its recreation ideas are applicable to smaller hospitals and pediatric units. Miss Feinauer be-

lieves that programs could be set up easily by a community volunteer if a regular recreation director were unavailable. Miss Feinauer has the following suggestions for those interested in a good recreation program:

1. Keep plenty of toys and games on hand. Volunteer groups can make and contribute most of these. Record players are excellent; comparatively inexpensive they provide hours of entertainment for children.

2. Find someone in your community who is interested in music. Children love to sing. At Children's Hospital groupsinging is very popular. Lessons in music appreciation are being given this fall with the aid of records.

3. Have a storyteller who will come in and entertain occasionally. This is not as simple as it sounds, for it is very important to have someone who can really tell stories. Not everyone can, and children are quick to lose interest.

4. Plan parties for the children and let them help in the planning. Half the fun of any party or special event for children comes in having something to look forward to. They get double entertainment value in anticipating the party and sharing in its preparation.

5. Start a small handicraft program. It does not have to be elaborate, merely something that will give youngsters a sense of accomplishment. Most children most enjoy making something for their parents.

6. Start a patient newspaper. Miss Feinauer helps her patients put out "Patients' Patter," a mimeographed sheet that comes out occasionally, and is extremely popular. The children do the art work, write the articles and deliver the finished product throughout the hospital. The children derive a great deal of enjoyment in both producing and reading this little paper and the cost is negligible.

Council Organized for Better Child Care

The National Council on Infant and Child Care, Inc. was formed recently in New York by 17 physicians, leaders in pediatric medicine.

Council members are associated with more than a dozen medical schools and children's centers throughout the country.

Allan M. Butler, M.D., professor of pediatrics, Harvard Medical School, and chief, Children's Medical Service, Massachusetts General Hospital, Boston, will serve as president.

The council, which is independent and non-profit, has been formed for the purpose of providing medical counsel in the utilization of mass media of communications.

Margaret Lyman, M.D., former research fellow, U.S. Public Health Service, State University of Iowa, has been appointed educational director.

Stouffer Corporation Enters Hospital Feeding Field

The Stouffer Corporation, national restaurant chain and frozen prepared food manufacturers, recently entered the hospital feeding and dietetic fields.

The complete Stouffer system of food purchasing, preparation and production was installed at Temple University Hospital, Philadelphia, Pa., October 15. Temple University Medical Center has just completed a development program raising its hospital bed capacity to 1,000 and its estimated annual admissions to 30,000.

Medical Writers' Service Award To Dr. Morris Fishbein

Recipient of the 1956 Distinguished Service Award given by the American Medical Writers' Association is Morris Fishbein, M.D., Chicago.

Dr. Fishbein is medical editor of Excerpt Medica, and was formerly editor, *Journal of the American Medical Association.*

A plaque and gold medal were presented to Dr. Fishbein by Richard M. Hewitt, M.D., Mayo Clinic, president of the association, at a banquet held at the 13th annual meeting in Chicago on September 28.

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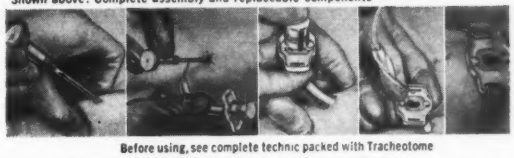

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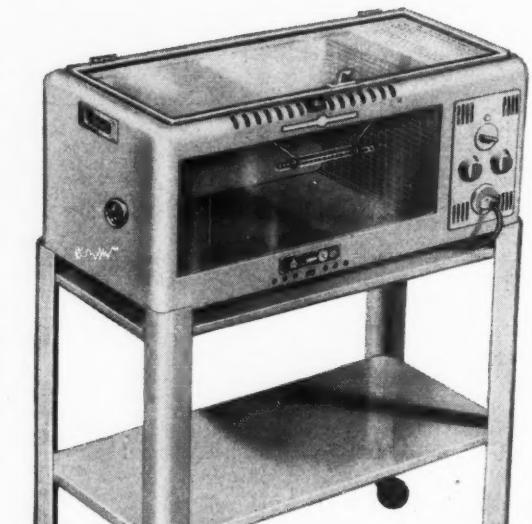

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- Postmaturity
- Cervical Incompetency
- Care of Pregnant Cardiac Patient

From papers presented before obstetrics and gynecology sessions at the 42nd annual clinical congress of the American College of Surgeons, HOSPITAL TOPICS has selected several of interest to the obstetrical nursing staff. The report on the entire congress begins on page 90 of this issue.

Postmaturity Cannot Be Anticipated As Clinical OB Problem

No Increased Fetal Mortality
Among Postmature Group Studied

Approximately 5,000 patients, both private and service, were followed by personal interview regarding their menstrual history and the calculated date of delivery, to see whether postmaturity actually occurs as a clinical problem and, if it does, whether or not it carries any increased risk for the baby.

All fetal mortalities were autopsied in order to determine the actual cause of death. While the final analysis of this series has not been completed, it is safe to state that the following conclusions will be made:

(1) Postmaturity cannot be anticipated as a clinical problem of obstetrics.

(2) There is no increased fetal mortality among the postmature group.

(3) As shown by the autopsy findings, this fetal mortality cannot be improved by termination of pregnancy at or soon after the expected date of delivery.

(4) There does not seem to be any indication for termination of pregnancy because of postmaturity. — **Edward H. Bishop, M.D.,** Philadelphia.

Cure Rate in Cervical Cancer Poor In Late Pregnancy and Postpartum

Early Diagnosis, Treatment Essential;
Biopsies No Hazard to Gestation

The crucial problem in cervical cancer remains that of earlier diagnosis and treatment. The cure rate in the last half of pregnancy and in the postpartum period is poor. The treatment is difficult to outline. We used radiation and surgery and a combination of both in our study.

Survival depends upon the stage at which the disease is discovered and treated. In a summary of various studies, it is found that cervical cancer complicates one in 2,000 obstetrical cases; pregnancy complicates one percent of all cervical cancers.

The average age of the patient with cervical cancer is 33.3 for the pregnant woman; 47.2 for the nonpregnant. The majority parity is 4 to 5; the average 4.9.

Vaginal bleeding was a symptom in 77 percent of the patients. Fourteen percent were asymptomatic, and nine percent had abnormal labor. Diagnosis is made by examination at onset of pregnancy, cytology, and biopsy.

There is no evidence to suggest that pelvic examination in the early stages of pregnancy can precipitate abortion. Multiple biopsies can be performed during pregnancy without affecting gestation.

Between the 28th and 34th weeks of gestation, cesarean interruption is indicated as soon as fetal sounds are present. The classical type of section is preferred to a supracervical because of the danger of cutting into tumor in the latter technic.—**Robert W. Kistner, M.D.,** Brookline, Mass.

X-Ray Valuable in Detecting Dermoid Cysts of Ovary

Opposite Ovary Should Be
Inspected at Operation

The two most common surgical complications of pregnancy are appendicitis and dermoid cysts of the ovary. X-ray detection of the latter is valuable and harmless to the pregnant patient, and when the diagnosis is made, removal should be accomplished without waiting for symptoms to develop.

Twenty-five percent of dermoids are bilateral and, whenever possible, the opposite ovary should be inspected at operation. If it also is involved, resection only should be performed to avoid sterilization and possible abortion of the patient.

In abdominal pregnancies, there is no treatment other than surgical intervention. Any pregnant patient with anemia for which there is no apparent cause should be suspected of ectopic pregnancy. Convenient detection is sometimes afforded by cursory examination of the tongue. Extreme pallor in the absence of any blood loss often indicates this complication.

Experience shows that hydatidiform moles need not be removed, as they will regress with time.

Myomectomy is a rare surgical complication of pregnancy, and in a patient without symptoms need never be done, regardless of tumor size. When removal is imperative, the myoma should be carefully shelled out.

Bicornuate uterus should also be suspected in pregnant patients with abdominal pain.

Decisions in diagnosing these complications are difficult to make, and surgery is seldom performed under ideal conditions. The fear of operating of the pregnant patient is unfounded. With adequate anesthesia and adequate oxygenation, abortion is relatively infrequent. Abortion cannot be prevented by procrastination, and often the irritation caused by the tumor or infection is

(Continued on next page)

enough to thwart normal delivery.—**Robert H. Barter, M.D.**, Associate Professor, Obstetrics and Gyneocology, George Washington University School of Medicine, Washington, D.C.

New Surgical Approach Promising For Treating Cervical Incompetency

Should Decrease Fetal Losses

Up to the present time no method of treatment has been effective for habitual late abortion at the fifth or sixth month of gestation, due to cervical incompetency. The surgical procedures for the correction of this condition have the disadvantage that they cannot be done during pregnancy.

A new surgical approach which utilizes a strip of the patient's fascia lata has been described recently by Shirodkar of India. The fascia is applied to the incompetent cervix in early pregnancy. In the form of a purse string, it is placed under the vaginal mucosa at the level of the internal os.

In seven patients who have had this procedure done, the results have been encouraging, although not quite as spectacular as those reported by Shirodkar. Our results, however, have shown continued improvement.

The operation represents a new procedure which should decrease fetal losses which occur as the result of cervical incompetency. It appears to have real merit in the management of this uncommon but particularly trying problem.—**Robert H. Barter, M.D., John L. Parks, M.D., James A. Dusbabek, M.D.,** and **A. L. Riva, Lt. Col., M.D.,** Department of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

Pregnant Patient with Heart Disease Needs Individual Study

Termination of Pregnancy Rarely Indicated; Critical Period Right After Delivery

The pregnant patient with heart disease can expect to have a normal delivery and a healthy infant; to be able to care for her baby and family, and to be able to undergo subsequent pregnancies.

Before reassurance is given in any of these areas, however, the patient must first be subjected to thorough physical examination and her cooperation elicited in carrying out instructions and advice—including that of hospitalization for long periods of time as necessary. Every pregnant woman with heart disease needs individual study and programming for her pregnancy.

Prenatal workup should be complete and unified with the use of all laboratory tests. Base line studies should be made and a continuous record kept. Prenatal care for the cardiac patient must include measures beyond those usual for the normal obstetrical patient.

Surgical treatment of valvular disease during pregnancy is a cooperative venture that should be limited in use. When indicated, it should be done as early in pregnancy as possible and rarely after 32 weeks.

The patient's previous history is important in plotting her obstetrical course. The patient with a history of failure without pregnancy will have trouble. Estimates of cardiac function should be made at regularly repeated intervals throughout the pregnancy. The most unfavorable lesion is that of rheumatic fever with fibrillation and recurrences of rheumatic fever.

AVOID TRANSFUSION IF POSSIBLE

Transfusion during pregnancy should be avoided when possible, but when unavoidable should be given with the patient in the sitting position rather than lying down. Infusion of red cells is preferable to infusion of whole blood.

Obesity and fluid retention are bad for the cardiac patient. Avoidance of both physical and emotional strain is necessary.

Toxemia is the most dangerous complication of pregnancy in patients with heart disease. Failure of response to therapy of toxemia is an indication for prompt delivery of the patient.

These patients tolerate operative delivery poorly, and the least traumatic means of delivery should be selected in each instance. Routine section of the pregnant cardiac patient is an outmoded technic. Depth of anesthesia is an important feature of their trauma. Shock must be avoided in patients with congenital lesions with large shunts, and large blood losses should be replaced promptly.

The work of labor is apparently not the factor that destroys these women, as the maternal deaths occur after delivery of the baby and placenta. Apparently immediately after delivery, something happens to the cardiac output. There is a sudden increase in plasma volume, a sudden release of blood from the distended veins of long extremities, and a drop in vital capacity—all of which mean a serious strain after delivery has been accomplished.

CARE DURING LABOR

The patient should be watched carefully during labor, and supportive oxygen therapy and digitalization instituted when necessary. The choice of anesthesia is best discussed with the anesthesiologist. Local block is probably best—supplemented with gas. The use of oxytoxics should be avoided. Both active and passive phlebotomy should be allowed. The critical period is reached immediately after delivery, and the patient must be watched carefully then also.

Termination of pregnancy in these patients is rarely indicated. Among a few exceptions are cases of progressive disability that persists in spite of thorough medical and surgical treatment; the Class IV patient—the patient with pure mitral stenosis, and the patient in early pregnancy with a previous history of failure.

Cardiac arrest is the most acute type of heart failure in obstetrics. The obstetrician should have a planned approach to treatment, because it can be well managed when recognized.—**Curtis J. Lund, M.D.**, Professor of Obstetrics and Gynecology, University of Rochester School of Medicine, Rochester, N.Y.

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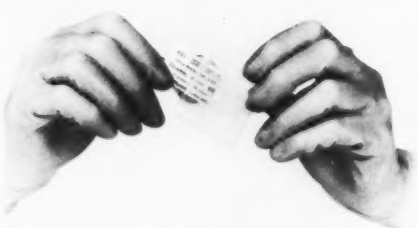

3. No more shattered tubes! Suture nurse quickly removes sterile, ready-to-use standard length or ATRAUMATIC needle suture, individually wrapped in easy-to-read label. Nurses report fewer worries about cut gloves, damaged linens and accidental tube breakage.

4. SURGILAR delivers more flexible gut! Suture nurse quickly straightens loose coil of superior gut. Surgeons report D & G SURGILAR delivers a stronger, more flexible strand of gut, free from kinks and weak spots often caused by tight reel-winding. Costs no more than tubes.

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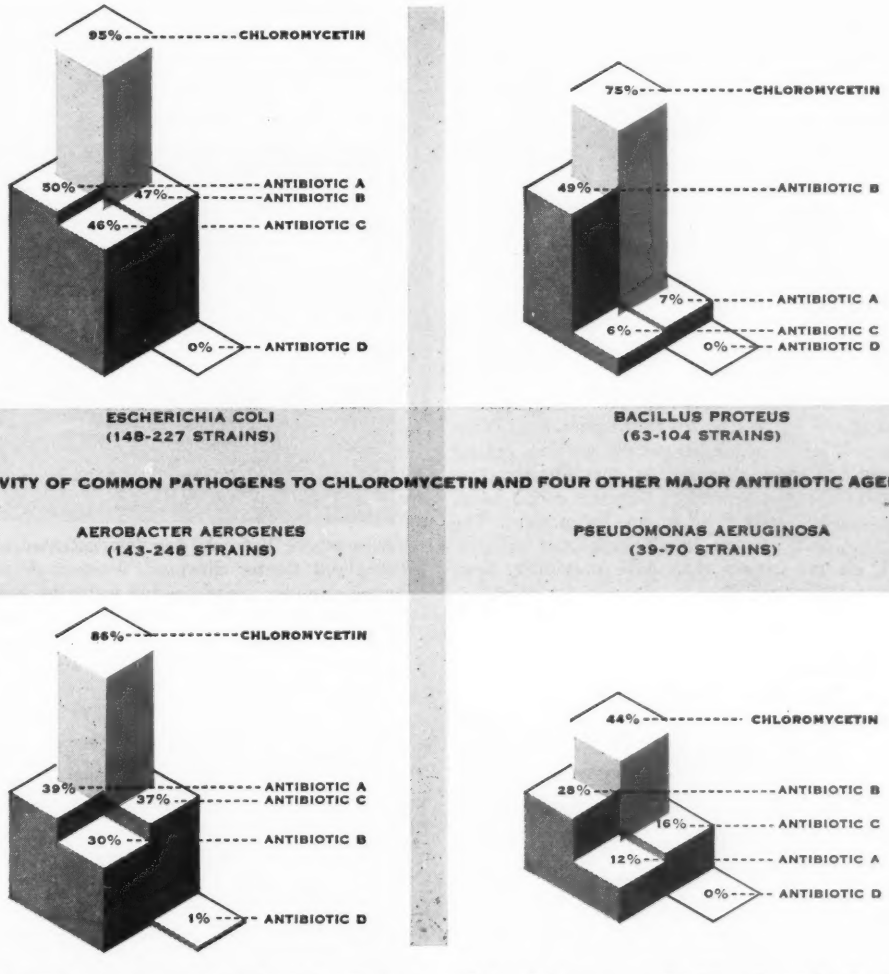

*This graph, based on *in vitro* studies, is adapted from Horton, B. E, and Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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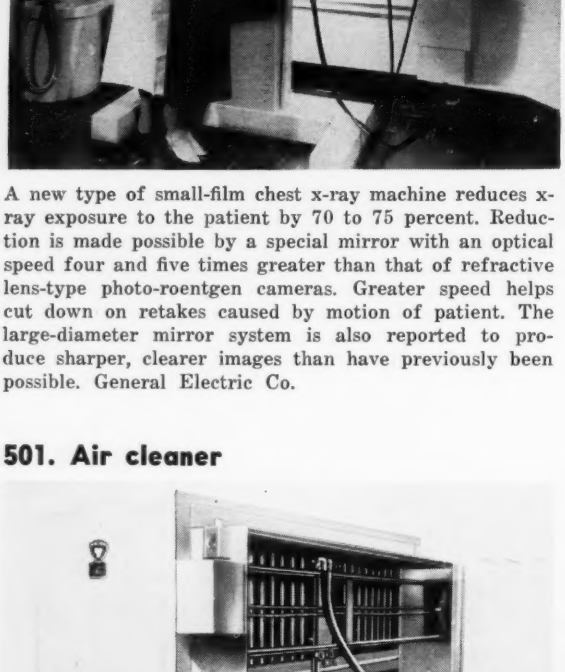
50024

BUYER'S GUIDE

Barbara Work
Buyer's Guide Editor

For futher information on any of the products, please check the Buyer's Guide number on the reply card facing page 80.

500. X-Ray machine



A new type of small-film chest x-ray machine reduces x-ray exposure to the patient by 70 to 75 percent. Reduction is made possible by a special mirror with an optical speed four and five times greater than that of refractive lens-type photo-roentgen cameras. Greater speed helps cut down on retakes caused by motion of patient. The large-diameter mirror system is also reported to produce sharper, clearer images than have previously been possible. General Electric Co.

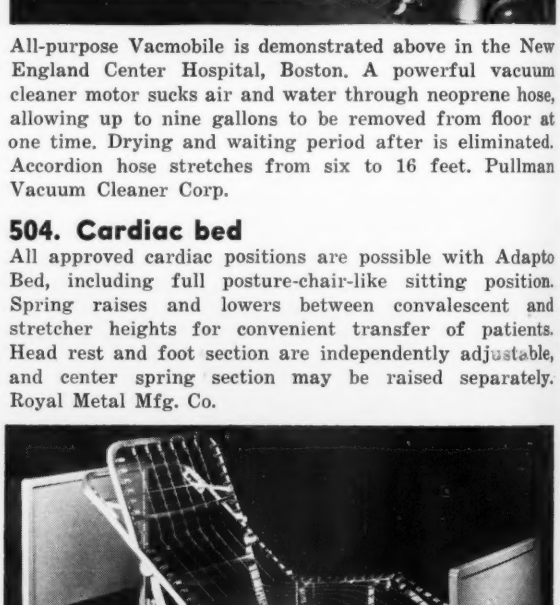
501. Air cleaner

Electronic air cleaner, built into the return air duct of heating and cooling system, will deliver air that is 95 percent pure, according to manufacturer. Airborne dirt and germs pass through invisible electronic curtain, are charged with 13,000 volts of electricity, and drawn to grounded plates. Push-button operation cleans the cleaning apparatus automatically. Trion, Inc.

502. Sealed bearing caster

Maximum load rating of wheel is maintained by new type of sealed bearing caster recently introduced. Caster has lip-type neoprene seal which effectively seals both swivel races and wheel bearings against dirt, grit, water, acids, and other contaminants, according to manufacturer. It is available in casters with steel, plastic, V-groove and moldon rubber wheels. The Colson Corp.

503. Floor cleaner



All-purpose Vacmobile is demonstrated above in the New England Center Hospital, Boston. A powerful vacuum cleaner motor sucks air and water through neoprene hose, allowing up to nine gallons to be removed from floor at one time. Drying and waiting period after is eliminated. Accordion hose stretches from six to 16 feet. Pullman Vacuum Cleaner Corp.

504. Cardiac bed

All approved cardiac positions are possible with Adapto Bed, including full posture-chair-like sitting position. Spring raises and lowers between convalescent and stretcher heights for convenient transfer of patients. Head rest and foot section are independently adjustable, and center spring section may be raised separately. Royal Metal Mfg. Co.

505. Catheters

Schuco latex balloon retention and hemostatic catheters, designed by Frederick E. B. Foley, M.D., feature a newly-developed, honey-like translucent latex material which allows visual control and inspection in depth for the first time. Balloon catheters also have streamlined body, unobstructed lumen, and double-safety inflation terminals. Medical Products Division, Schueler & Co.

506. Sphygmomanometer

New hand-model sphygmomanometer has gauge separate from cuff. Inflating bulb and air-release valve is built into back of gauge, and whole unit fits any size hand comfortably. Connecting tube is two feet long, enabling doctor to observe blood pressure reading easily without patient being able to see it too. Release valve is controlled by large thumb screw, producing slow, uniform deflation of cuff pressure. Taylor Instrument Companies.

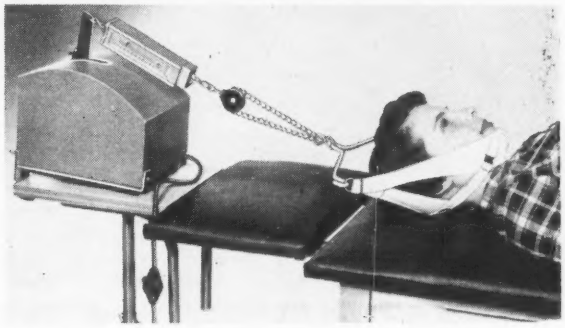
507. Copying machine

"Secretary" copying machine has been restyled to permit use of a new white copy paper. This expands "Thermo-Fax" copy paper range to five colors — yellow, green, buff, pink and white. Two new machines include the "Premier," which copies from any material regardless of its thickness, and the "Fourteen," a machine which copies material up to 14 inches wide. Minnesota Mining and Mfg. Co.

509. Papaya nectar

One quart can of Papaya-Vita nectar concentrate makes one gallon of juice. Concentrate contains natural papaya juice and pulp, and no coloring or preservatives have been added. It is rich in vitamins A and C and enzyme papain, according to processor. No refrigeration is required until it is mixed. Stevens Tropical Plantation.

510. Portable traction machine



Motorized portable intermittent traction machine provides both vertical and horizontal traction. Tractomatic machine is simple to operate and easily adjustable. Has two speeds. Traction may be set accurately by an adjustment on the arm, or by lengthening or shortening the chain to the arm. Tru-Eze Mfg. Co., Inc.

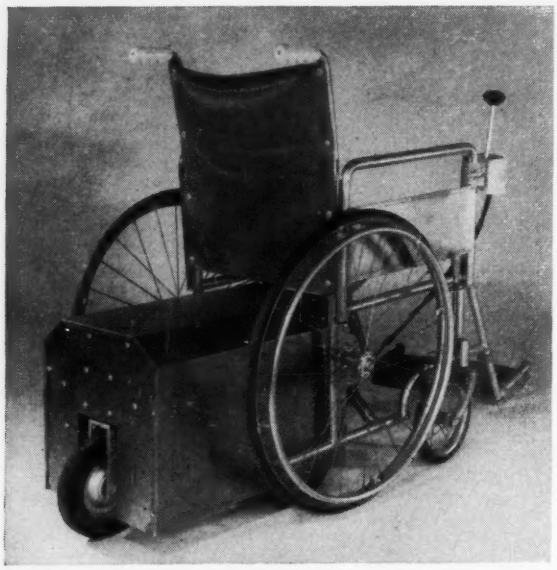
511. Laundry unit

Two Roto-Matics comprise a hospital unit, as one handles the large lays, on uniforms, coats, etc., and the other handles all small lays. With an operator for each machine, it is possible to turn out 60 or 65 garments in an hour. Manufacturer states that any wearing apparel used in a hospital can be laundered by the Roto-Matic unit. Unipress Co.

BUYER'S GUIDE

Continued

512. Wheelchair motor



"Chair Boy" is the only completely self-contained motorized drive, fitting most outdoor-type tubular wheelchairs. It features the Unimatic single adjustable arm control providing two forward speeds, one reverse speed, steering, and smooth braking. "Chair Boy" is easily coupled or uncoupled in one minute, often by patient in the chair. General Medical Equipment Corp., Division of Lumex, Inc.

513. Ophthalmologic chair

Designed for use in eye, ear, nose and throat surgery, oral surgery, and outpatient clinics, ophthalmologic chair is hydraulically operated by foot press and may be fully reclined for minor operations. Jack A. Sable, at AHA convention, showed chair to Sister Emilene, administrator, Divine Providence Hospital, Williamsport, Pa. F. & F. Koenigkramer Co.

514. Clinical audiometer

A clinical two-channel audiometer that conducts nearly all types of hearing tests with speed and accuracy has been designed for use by physicians, clinicians, and audiologists, in either one or two-room arrangements. The audiometer also can perform all types of speech tests, including live voice and recorded. It has fewer components and thus requires less maintenance. Beltone Hearing Aid Co.

515. Ultrasonic cleaner

Instrument cleaner utilizing high-frequency sound waves to achieve superior and more economical cleaning was introduced at the American Hospital Association convention in Chicago. Cold water or a water-detergent solution may be used to clean as many as 100 instruments at once, 10 times faster than hand methods and at one-tenth the cost, according to manufacturer. American Sterilizer Co.

516. Germ-killing paint

Interior wall paint that kills germs on contact, with no harmful effect on people or animals, will soon be marketed in the U.S. The paint contains Anti-Pathogenic Reagent, a powerful, odorless, non-poisonous additive which creates a reaction in paint that will kill germs and organisms on contact. Reaction is said to last for two years or more. Jones-Blair Paint Co.

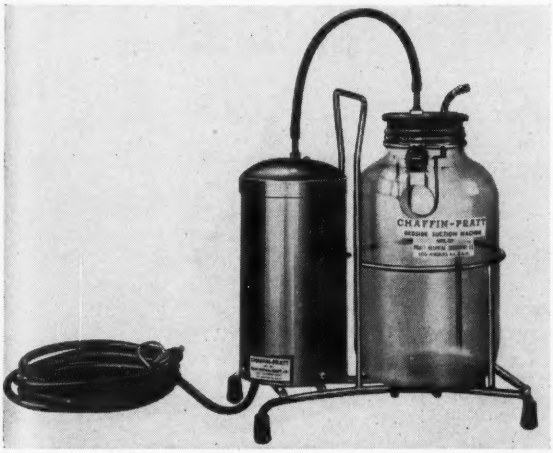
517. Cleaner concentrate

Randu, an all-purpose concentrated cleaner, is effective on linoleum, tile, wood, leather, asphalt and vinyl tile, upholstering, carpeting, painted surfaces, and any material not harmed by water, according to the manufacturer. It requires no rinsing, and does not contain lye or abrasives. Kusiel Chemical Co.

518. Portable sitz bath

"Toilaflo" sitz bath has continuous flow of temperature-controlled water over involved parts. Suspended seat is supported by flexible, washable rubber straps allowing necessary opening and cleaning. Tub is also removable for cleaning. National Sales Co.

519. Suction machine

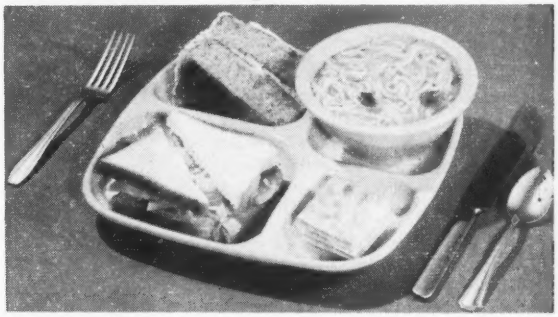


Bedside suction machine weighs only 6½ lbs. complete. Collection jar is a one gallon mayonnaise or pickle jar. Operated by electricity for any length of time desired, it has no motor, makes no noise, and does not get hot. Positive overflow trap is mounted on special rubber stopper. Rim prevents stopper from being forced down into bottle. Pratt Hospital Equipment Mfg. Co.

520. Vinyl plastic dressing

Above: Aeroplast dressing, a vinyl plastic dressing, is sprayed directly onto the lesion from an aerosol container. It can be used as the sole dressing over clean, dry wounds, or with one or more layers of gauze where moisture is present. It maintains sterility as long as it remains intact, manufacturer says. Aeroplast Corp.

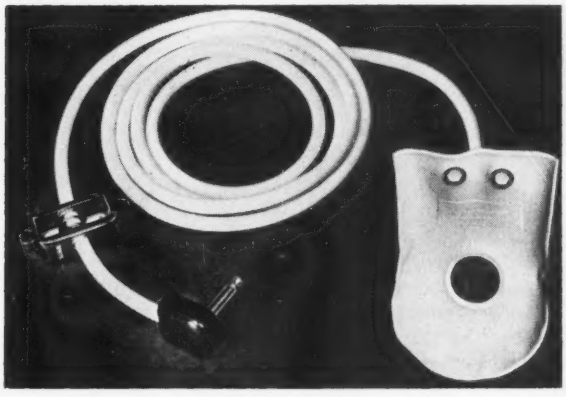
521. Melamine tray



"Lunchamp" tray is more compact, according to manufacturer, than previously available trays, and smaller in over-all dimensions, but has greater capacity because of its deeper, proportioned walls. Design features include rounded, easy-to-clean corners, and provisions for thorough aeration, drainage, and level stacking. Chicago Molded Products Corp.

522. Pillow speaker jacket

New, improved Executone pillow speaker features protective, shock-proof Bolta vinyl-foam jacket which is easily removed for sterilization. Speaker, measuring 4½ x 3⅛ inches, is equipped with a six-foot cord and stainless steel security clamp that grips patient's bedsheet or pillow case. Jacket from General Tire & Rubber Co.



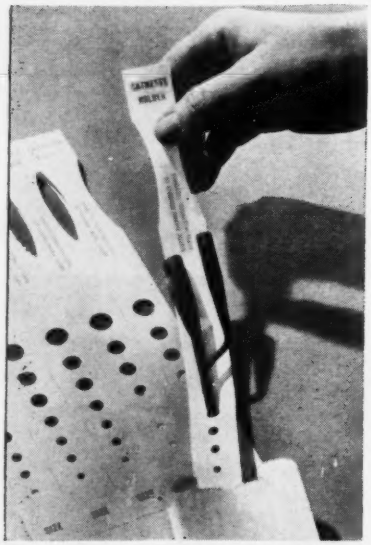
BUYER'S GUIDE

Continued

523. Blood-shipping container

Corrugated box with inner and outer laminations of aluminum foil for long-distance shipping of whole blood eliminates expense of storing or returning standard container. Temperatures of between 2° and 10° C. can now be maintained for 30 hours. Carton also weighs 3 lbs. less than conventional boxes when packed with 4 pints of blood and iced for shipment. Aluminum Co. of America.

524. Catheter holder

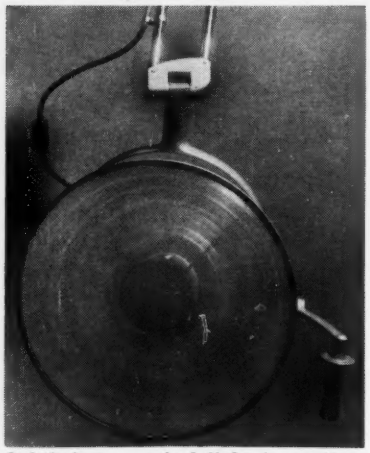


Removal of catheters from sterilizing bags or tubing is simplified with catheter holder. Catheter is inserted through proper size hole in holder, with holder tab protruding from sterilizing bag or tubing. Aseptic-Thermo Indicator Co.

525. Hot-chocolate mix

"Hot cocoa" mix dissolves in hot water to make hot cocoa, or in ice water for a cold chocolate drink. Contains all the milk nutrition of a fresh chocolate drink and has a creamy flavor. Power mixer or vigorous stirring unnecessary. Comes in 25-lb. size for volume operations. Carnation Co.

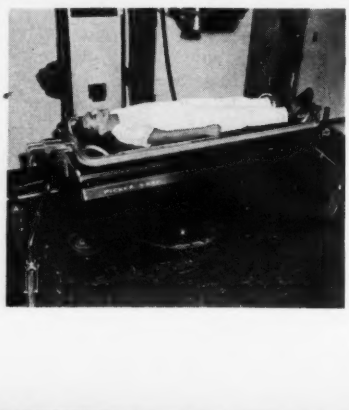
526. Surgical light



Ophthalmic surgical light is particularly applicable to large-area eye surgery, according to the manufacturer. Lamp comes in three forms, each with adjustable focusing device. Wilmot Castle Co.

527. Patient handler

Once placed on litter of Transaver, patient is transported anywhere within hospital without again being moved. X-ray table is shown with Transaver Patient Handler to demonstrate how radiographs are taken without patient being moved from litter. Picker X-Ray Corp.



528. Cubicle track

Cubicle curtain track, of aluminum construction, can be installed either as a flush or surface-mounted unit. "Bumper-to-bumper" feature keeps wheels of one carrier from fouling with the next. Manufacturer believes "Cubi-Trac" to be the quietest such track available. ADC Cubicle Track Corp.

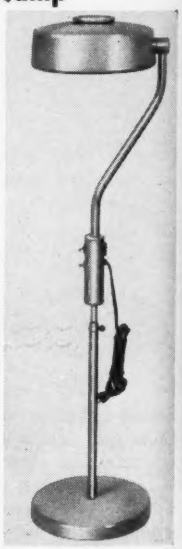
529. Oven-sterilizer

"Space Saver" Force-Aire oven and sterilizer has working chamber of 19" x 19" x 19". Occupies only 31" on bench instead of usual 49". Interiors and shelves are of stainless steel. Dial thermometer in door indicates chamber temperature. Labline, Inc.

530. Ultrasonic unit

Portable ultrasonic unit weighing 25 lbs. is a therapeutic instrument generating sufficient power for all ordinary therapeutic purposes. Burdick Corp.

531. Bedside lamp



Height of bedside lamp is adjustable to correspond with variable height of hospital beds. Internal bulb shield supplies reflected light for both direct and indirect illumination. Switches, plug-in receptacle, and night light are at mattress height easily reached by patient. Entire lamp swivels in upright standard. Adjustable Fixture Co.

(Continued on page 73)

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SELF-RETAINING RETRACTORS

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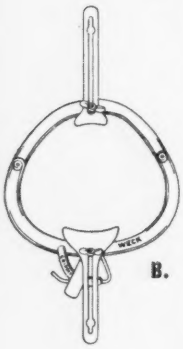
A.



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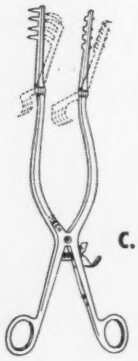


C.

D.

The Weck line of self-retaining retractors – only a few of which are shown here – includes a type for practically every operational requirement. Like all Weck surgical instruments, Weck retractors are precision manufactured – with faithful adherence to the original design specifications of each instrument. All are made of the finest Weck Stainless Steel and all carry the famous Weck guarantee. At a slight extra cost Weck self-retaining retractors may be had with the new Weck "Glare-Proof" Finish, which effectively eliminates reflected glare, yet maintains the corrosion-resistant, ease-of-cleaning properties of Weck Stainless Steel. Many are equipped with the remarkable GRIPPIT ratchet, which assures a non-slip hold, after a quick and simple adjustment to the desired opening and size of the operating field.

A. **O'SULLIVAN-O'CONNOR SELF-RETAINING ABDOMINAL RETRACTOR** (shown in collapsed position, ready for the first adjustment) is now Weck-made, with no changes in the original pattern or price. Complete with two fixed and three separate adjustable blades (two narrow, one broad) and Grippit ratchet.

B. **O'SULLIVAN-O'CONNOR RETRACTOR** expanded in operating position with one broad and one narrow blade.

C. **BECKMANN THYROID OR MASTOID RETRACTOR** with parallel opening blades on hinges so handle may be held away from field. Grippit ratchet.

D. **WEXLER TRANSVERSE INCISION RETRACTOR** with wound spread up to 5½". Large spreader blades hold full thickness of abdominal wall away from field. This same frame, with other blades, forms the Wexler-Balfour and the Wexler-Balfour *deep* abdominal retractors.

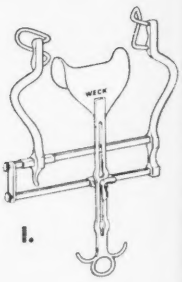
E. **WEXLER ABDOMINAL RETRACTOR**, consisting of a frame with 2 removable sliding blades. Also available to fit this frame are universal joints (which allow blades to be held securely at any position, angle or depth), as well as silver plated flexible copper, Deaver-type and Wexler expandable blades.

F. **FRAZIER LAMINECTOMY RETRACTOR** with one 3- and one 4-prong adjustable blade. An excellent general purpose retractor, good also for spinal fusions.

G. **WEITLANER RETRACTOR** with 3 x 4 sharp or blunt pointed blades, for use in small operating fields. Grippit ratchet.

H. **HOEN LAMINECTOMY RETRACTOR** with 2 sets of easily detachable blades in 2 sizes. Special blades for other uses can be supplied to order. Grippit ratchet.

I. **BALFOUR RETRACTOR** with two fenestrated end blades, one solid center blade, with spread between blades up to 6". A variety of center blades are available to fit the frame.



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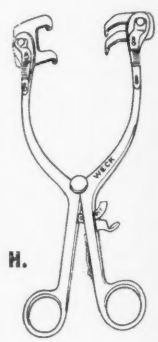

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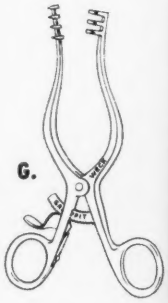

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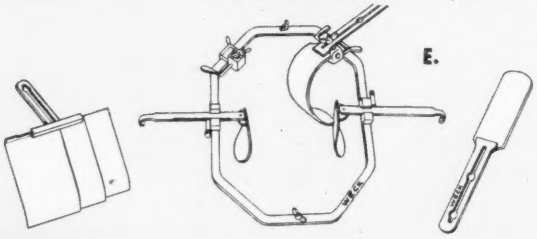

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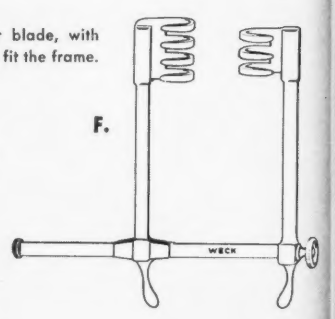

F.

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532

533

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Multi-
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Pyle

532. Presterilized needles

Standard American Luer needles are now available presterilized in individual reusable nylon cases that protect the points. Autoclaving and cleaning of new needles are eliminated. Sterile Damascus needles in "Needletainers" are available in nine standard needle sizes. MacGregor Instrument Co.

533. Milk dispensers

Bulk milk dispensers automatically deliver pre-set controlled portion of refrigerated milk. Portion control can be maintained from 1 to 32 oz., and delivery rate can be metered up to 4 oz. per second. Adaptable to push-button delivery or coin-box operation. Meterflo Dispensers.

534. "Chamois-like" mop

Made of chamois-like material which helps loosen sticky and greasy spots, mop is said to result in cleaner, drier surfaces in less time. Manufacturer states that mop is virtually unaffected by bleach and strong cleaners, absorbs 600 percent of its own weight in water, will not sour. Lowndes Products, Inc.

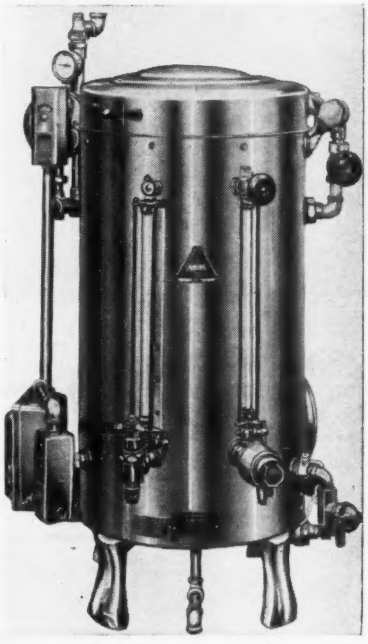
535. Lighting fixture

Multi-Vent Troffer is a dual-purpose ceiling fixture which provides both air distribution and lighting. Looking like a regular recessed fluorescent light fixture, it has a completely concealed, built-in air diffuser, and is adaptable to any drop-type ceiling. Pyle National Co.

536. Autoclave ink

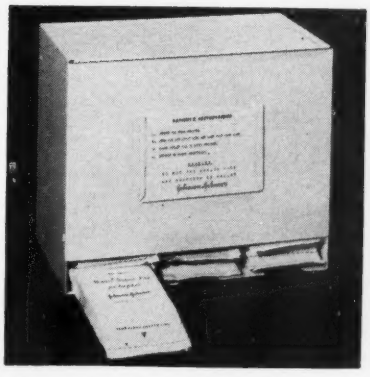
Ink is red when applied, turns green when autoclaved. May be applied with an automatic pencil containing leads of ink in compressed form, or with stamp and foam-rubber stamp pad. Edward Weck & Co., Inc.

537. Coffee maker



All models are self-contained units, siphon type, permitting 100 percent extraction with one infusion, thus eliminating hand pouring or re-pouring. All-glass interior prevents bitter flavor through contact with metal. Models are electric (4-gallon Lowboy Jr. is shown above) gas, or steam. Amcoin Corp.

538. Dispenser



Dispenser for "Pre-Wrap" Super Modess pads is constructed of heavy-gauge steel, finished in white baked enamel. Pads are dispensed through one of three slots. No sharp edges; nothing to rust. All seams are spot-welded. Blank card is furnished for hospital's own instructions to patient. Johnson & Johnson.

539. Conductivity tester

Battery-operated and fully portable conductivity tester can be used to test conductive flooring, furniture, personnel, mattresses and pads, rubber tubing and equipment. Meets NFPA standards. Meter face is color-coded for easy readings. Associated Research, Inc.

Specially Formulated To Combat Hospital Odors . . .
(severe burns, cancer, gangrene, etc.)

Re-Odit ™

ONE BOTTLE controls room odors from four to ten weeks . . . . .

ONE DROP banishes bedpan odors for 4 or 5 hours after use . . . one drop keeps colostomy patients odor - free for 24 hours.

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Makers of CLYSEROL, original low-fluid enema in disposable container.

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Hospital Economy Pack

FLEET® ENEMA
Disposable Unit
Now in individual carton with lubricant

Handy, Economical, Practical . . . That's the FLEET ENEMA Hospital Economy Pack. Contains forty-eight individually packaged, complete units, including lubricant. Each carton provides space at the top for patient's name and room number.

FLEET ENEMA is the *only* Disposable Unit with a plastic squeeze bottle designed for easy, one-hand administration . . . with a rectal tube anatomically patterned to minimize injury hazard . . . with a built-in diaphragm to regulate flow and prevent leakage . . . saves nearly 28 minutes of attendent's time per enema. That's why it's the Disposable Unit of choice in the top ranking hospitals.

33 3/4¢	4 doz.
32¢	12 doz.
30 5/8¢	24 doz.
30¢	48 doz.

H E P is supplied in *full cases only*

For a quality disposable unit at a *budget price*, order "FLEET ENEMA, H E P." from your wholesale druggist or hospital supply house.*

**When ordering less than 4 dozen, specify "FLEET ENEMA, Standard Unit."*

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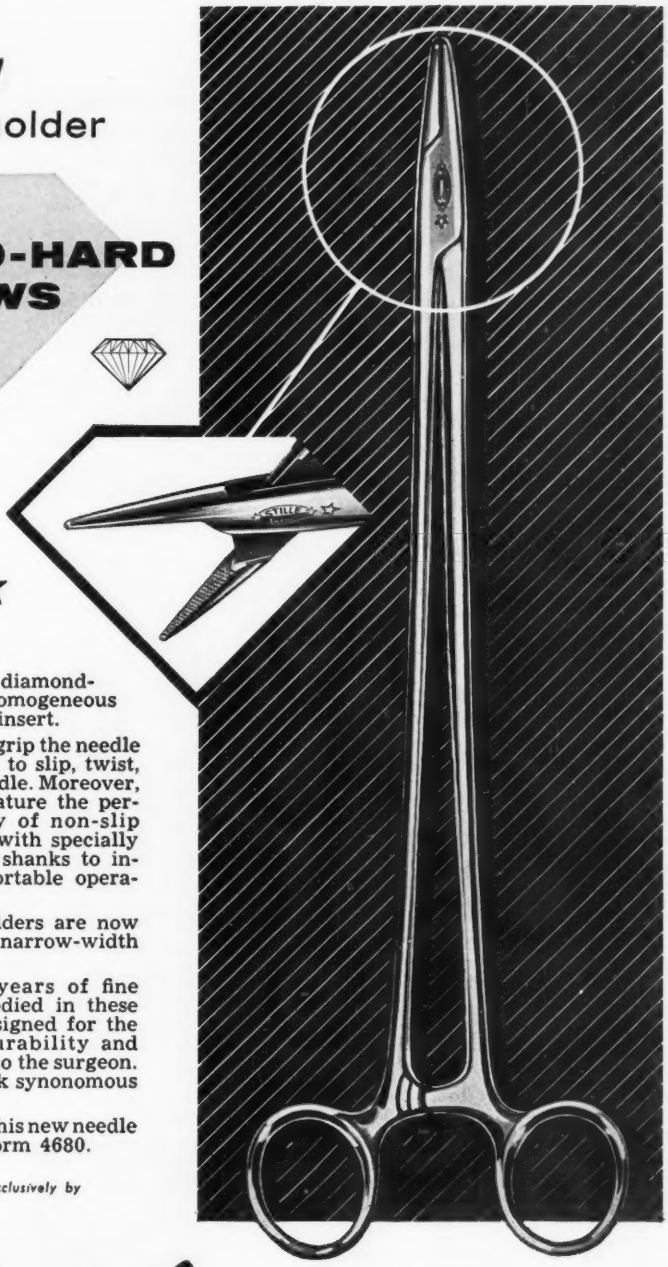
Lynchburg, Virginia
Makers of Phospho®Soda (Fleet) A laxative of choice for over 60 years.

a **NEW**
needle holder

with
DIAMOND-HARD JAWS

by

STILLE
SWEDEN



This needle holder has a diamond-hard gripping surface, homogeneous with the jaw not an insert.

The diamond-hard jaws grip the needle *firmly* with no tendency to slip, twist, scratch, or break the needle. Moreover, Stille needle holders feature the permanent holding ability of non-slip three-and-one ratchets, with specially designed and tempered shanks to insure positive and comfortable operation of the instrument.

These new needle holders are now available in normal and narrow-width jaws from 5½" to 11".

Over one hundred years of fine craftsmanship are embodied in these instruments. Each is designed for the utmost in strength, durability and "feel"—all so important to the surgeon. They bear the trade-mark synonomous with quality — Stille.

For further details on this new needle holder please request Form 4680.

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To centralize all operations, headquarters for Stille Instruments has been moved from New York City to Madison, Wisconsin.

BUYER'S GUIDE

Continued

541. "Quiet" poster

Nurse Jeanne Hawk, Eli Lilly and Co.'s industrial medicine and safety department, shows how to get quiet for patient. Poster, to caution visitors in a diplomatic way, is available to hospitals and clinics. Eli Lilly and Co.

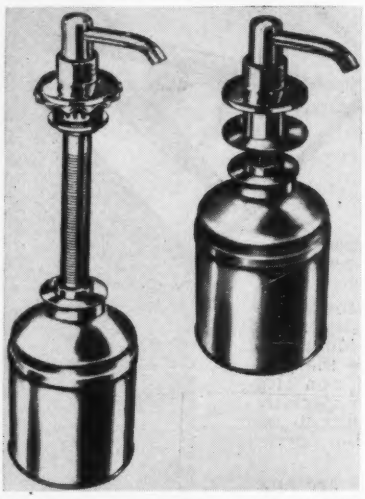
542. Instrument table

Stainless steel instrument table adjusts to wide range of heights. V-shaped rest rods increases stability; conductive rubber rollers on bar base aid maneuverability. Trays are easily removed for autoclaving. American Hospital Supply Corp.

543. Medical staff bylaws

Revised edition of "Model Bylaws, Rules, and Regulations of the Medical Staff" is now available. Sets conform to principles issued by Joint Commission on Accreditation of Hospitals. Four sets are available: for hospitals with less than 75 beds; hospitals with 75 to 150 beds; hospitals with over 150 beds; and hospitals with usually less than 50 beds. Physicians' Record Co.

544. Soap dispensers

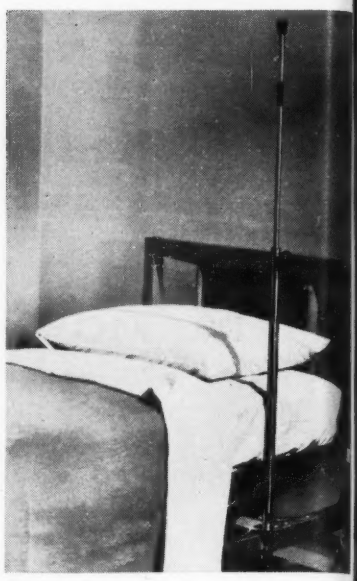


Basin-type soap dispensers for liquid soap have been re-designed and improved. Extension adapter solves problems of poor clearance under the basin. Easily refilled from the top. Bobrick Dispensers, Inc.

545. Needletainer

Moulded nylon needle container may be re-used indefinitely for sterile storage of needle. Compact in size and unbreakable, Needletainers are easily stored. Shape prevents point of needle from blunting against bottom. Caps are available with needle gauge and length, or plain. Sterilon Corp.

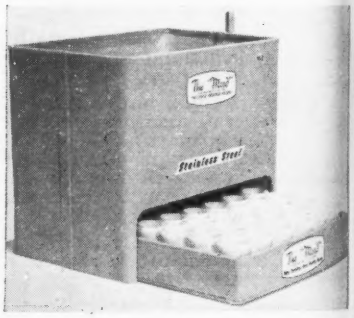
546. Irrigating stand



Chieftain irrigating stand clamps firmly to bed frame. Rod telescopes from 41⅝" to 65½" from clamp. Double deep hooks hold bottles securely against upright, which is covered with black rubber tubing to prevent breakage or clanging. American Hospital Supply Corp.

547. Creamer-filler

Multiple creamer-filler is now available in stainless steel, with double racks for filling, serving, and washing. Twenty-four standard coffee cream-



ers are filled simultaneously in four seconds, with fingertouch control. Filler dispenses into either ¾ or ½ oz. jars with no messy jars or cream loss. 'Mood' Enterprises, Inc.

548. Tray dispenser

New cantilever-type tray dispenser is designed to store and dispense at service level up to 150 trays. It features all stainless steel construction, push-pull handle, and all-swivel, rubber-tired casters. Lowerator Division, American Machine & Foundry Co.

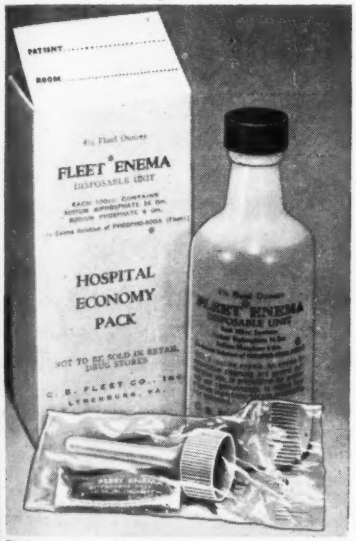
549. Disposable oxygen mask

Disposable Chieftain oxygen mask is made of pliable polyethylene. Air vent holes on nosepiece permit proper administration, safe-guard patient in event of blocked inlet line. Individually packaged in clean plastic bag ready for use. American Hospital Supply Corp.

550. Louver-diffuser

CurtiCell, electronically sealed plastic louver-diffuser enclosure for lighting fixtures, combines molded cellular louver bottom and flat top diffusing panel into one unit. Cellular portion controls direct glare. Frosted diffusing panel reduces reflected glare. Curtis Lighting, Inc.

551. Enema pack



Redesigned hospital economy pack provides squeeze bottle, rectal tube, and lubricant for single enema in an individual package. New long-neck bottle and tapered rectal tube permit easier administration of enema. Package top has space for patient's name and room number. C. B. Fleet Co.

552. Rubber foam mattress

Double coring of Koylon foam rubber mattress makes it completely reversible, also permits a greater ventilating area and eliminates the "hammocking effect." Mattress is washable and can be sterilized by conventional methods. U. S. Rubber Co.

553. Food warmers

Thermotainer electric food warmers have been redesigned, with streamlined interiors and exteriors. Many units now provide increased capacity without increased dimensions. Other features include electrical inspection access panels, slideaway dampers, removable compartments, fibre-glass insulation. Franklin Products Corp.

554. Reodorant

ReOdit, non-toxic reodorant, has been formulated to control difficult odors of severe burns, cancer, and gangrene. Packaged in 1-oz. bottles with pull-up wick for room use, and secondary screw cap for easy use by the drop. ReOdit is also highly effective against other odors. Clyserol Laboratories Inc.

555. Chart holder

Aluminum chart holders have round corners, smooth edges, and hinged top cover. Three-spring clamp securely holds up to ¼" of punched or unpunched sheets. With extension hanger, may be hung in racks or placed on shelves of chart desk. Physicians' Record Co.

556. Electronic resuscitator

Easy-to-apply resuscitator utilizes a method of driving the diaphragm with electrical pulses, without any discomfort or injury to the subject. A new type of current, "batronics," consists of a damped oscillation, of which the first half pulse is predominant. Batrow Laboratories, Inc.

557. Stocking aid

"Stocking-Aid" for the physically disabled is a device for putting stockings on and pulling them up into place. No danger of tearing or snagging nylon hose. Fascole Corp.

558. Postpartum care

Pre-Pack contains 12" Kotex maternity pad and four large Curity cotton balls, packaged in order of use. Bauer & Black.

559. Teaching aid

Spin-a-test provides intensified practice in remembering subject matter, in the form of a game, thus is highly suitable for short instruction periods of hospital schools. Supersized spinner attaches to blackboard, and words, numbers, symbols, or phrases may be written around the device. Spin-a-test Co.

BUYER'S GUIDE

Continued

Down the AHA Aisles

This page concludes a pictorial review of exhibits from the American Hospital Association convention, September 17-20, in Chicago. For other exhibit pictures, see pages 66-75 in the October issue of HOSPITAL TOPICS.

Above: Abe Soontup, Deknatel & Son, shows Name-on Beads cabinet in blue-enameled metal to Melvin E. McNab, director, DeGraff Memorial Hospital, North Tonawanda, N.Y. A560.

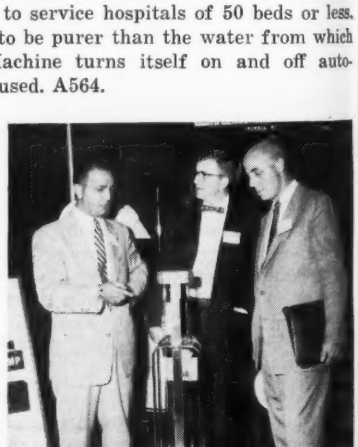
Above: Reginald Bates, J. Sklar Mfg. Co., shows malleable stainless steel retractor to N. S. Margileth, purchasing agent, Jewish Hospital, Cincinnati, O. A561.

Handie-Talkie radio paging system is demonstrated by Don Ross (r.), Motorola, to Pedro Jamovich, medical director from Brazil, and Mrs. Jamovich. Alerting buzz and voice message are heard in 10-oz. radio pager carried by individual, while other receivers remain silent. A562.

MOTOROLA
RADIO PAGING SYSTEMS FOR HOSPITALS

Above: Flowmeter Twins, "born" at the AHA convention, are shown to visitors by Doyle Howard (center), National Cylinder Gas Co. One of the twins was the first flowmeter designed specifically for the nursery and its special oxygen therapy problems. The other was the regular model, gauged from 0 to 15 liters of oxygen per minute and designed for regular hospital use. A563.

Above: Demonstrating the Cold Corporation's Chip-Freeze Automatic Ice Flaker are Dan Segal, Atlas Equipment Co., and Myron Roth, Cold Corp. This 560-lb. unit was primarily designed to service hospitals of 50 beds or less. Ice flakes are said to be purer than the water from which they are made. Machine turns itself on and off automatically as ice is used. A564.



Right: Nat La-Rocca (1.), Hanovia Chemical and Mfg. Co., tells J. Henderson, assistant superintendent, Presbyterian Hospital, Denver, Colo., and Herbert D. Moe, Colorado State Department of Health, Denver, about Safe-T-Aire, portable room air sterilizer. A565.

FILMS AND NEW LITERATURE

570. Booklet on "Incert"

Colorful booklet tells how to use "Incert," the one-step sterile additive vial for adding medication to parenteral solutions. Includes additives available in this preparation. Travenol Laboratories, Inc.

571. Floor-service leaflet

Protective coatings to improve the appearance, prolong the life, and ease maintenance of large floor areas are outlined in this 8-page pamphlet. Chemical Specialties Manufacturers Association.

572. Food pump

The Barron food pump is fully described in a 10-page booklet which also lists materials used for tube feeding, and methods for preparing these foods. Feeding tube preparation and delivery rate is also covered. ABCO Dealers.

573. Laundry equipment

Four-page supplement in two colors contains detailed, illustrated description of laundry equipment. Every phase of in-plant laundry operations, from washing to extracting, unloading, and ironing, is covered. U.S. Hoffman Machinery Corp.

574. Narcotic-ordering instructions

Regulations are given for ordering narcotics on Federal Narcotic Order Form. Booklet also lists items specified according to manner in which they should be ordered, with size of package obtainable, strength and form of medication. McKesson & Robbins, Inc.

575. Sterilizers brochure

Pictured and described are several types of hospital sterilizers. Available with the brochure is an illustrated price list of the complete line. Shampaine Electric Co.

576. Surgical instruments

Detailed descriptions of new and exclusive surgical instruments and specialties are included in this fully illustrated 42-page catalog. Of special interest to cancer and tumor clinics. United Surgical Supplies Co.

577. Dishwashing booklet

Tips on dishwashing are found in this 16-page two-color booklet. Discussed in detail are machine and hand washing of china, plastic ware, glassware, and pots and pans. Calgon, Inc.

578. Procedure manual

Revised Procedure Manual 1, "Safety Sides—a Proven Safety Measure," gives a more detailed account of effectiveness of safety sides. Manual is illustrated and contains several new features. Hill-Rom Co.

579. Plastic tubing booklet

Tygon Tubing formulations are covered individually and in technical detail, in 28-page manual. Includes applications and limitations of each formulation, physical properties and chemical resistances. The U.S. Stoneware Co.

580. Moniliasis film

"The Treatment of Moniliasis with Nystatin" presents case studies, photographed in color, of wide variety of typical moniliasis infections, and results of treatment with Nystatin. E. R. Squibb & Sons.

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The Book Corner

Booklets for Children

INSIDE THE HOSPITAL and ALL ABOUT AN OPERATION.

By Helen B. Radler. New York: Society of Memorial Center. 1956. 25 cents.

These two very interesting and delightfully illustrated booklets for children explain in simple language the reasons for hospitalization, operations, and the procedures involved.

"Inside the Hospital" likens a child's body to an automobile and draws an analogy between the breakdowns and repairs of cars and the human body. Hospital procedures are explained, as well as the functions of doctors and nurses. "All About an Operation" outlines briefly the procedures involved in an operation and in hospital care and the reasons for surgery.

They will aid immeasurably in preventing disturbances which even a short experience may provoke in a child.

Informative Booklet on Shyness

THE SHY CHILD. By Helen Ross. Chicago: Institute for Psychoanalysis. 1956. 25 cents.

Shyness is a kind of fear that follows pain or discomfort. It starts out as a "protective coloring" and soon shows up as a character trait, the author states.

This small, informative booklet will be of value to the parents of a shy child and to the teacher who may act as a bridge on which the shy child may build confidence in others.

Scientific Awards Handbook

HANDBOOK OF SCIENTIFIC AND TECHNICAL AWARDS IN THE UNITED STATES AND CANADA, 1900-1952. Edited by Margaret A. Firth. New York: Special Libraries Association. 1956. 491 pages. $10.

This new reference volume gives the criteria for selecting winners, type of award given, and a chronological list of recipients for each award granted by selected American and Canadian scientific and technical societies.

Also included, whenever possible, for awards granted after 1929, are papers presented in connection with awards and other specific related information.

The descriptive listings will be helpful to those concerned with granting, reporting, or establishing awards.

OR Safety

RECOMMENDED SAFE PRACTICE FOR HOSPITAL OPERATING ROOMS. NFPA No.56. Boston: National Fire Protection Association. 1956. 48 pages. 25 cents.

This edition supersedes the 1954 edition and includes a number of changes to bring it up to date.

Included are the requirement of uniform electrical receptacle and attachment plugs, and new material on differentiation between different types of rayon and other synthetic fabrics which must be strictly regulated to eliminate the danger of static electricity.

This pamphlet, while purely advisory, has been endorsed by the American College of Surgeons, the American Hospital Association, and the Veterans Administration.

Manual for Disaster

DISASTER FATIGUE. By the American Psychiatric Association Committee on Civil Defense. New York: Mental Health Materials Center. 1956. 35 cents.

(Continued on page 87)

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502. Sealed bearing caster
503. Floor cleaner
504. Cardiac bed
505. Catheters
506. Sphygmomanometer
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509. Papaya nectar
510. Portable traction machine
511. Laundry unit
512. Wheelchair motor
513. Ophthalmologic chair
514. Clinical audiometer
515. Ultrasonic cleaner
516. Germ-killing paint
517. Cleaner concentrate
518. Portable sitz bath
519. Suction machine
520. Vinyl plastic dressing
521. Melamine tray
522. Pillow speaker jacket
523. Blood-shipping container
524. Catheter holder
525. Hot-chocolate mix
526. Surgical light
527. Patient handler
528. Cubicle track
529. Oven-sterilizer
530. Ultrasonic unit
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553. Food warmers
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555. Chart holder
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558. Postpartum care
559. Teaching aid

DOWN THE AHA AISLES

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A561. Malleable retractor
A562. Radio paging system
A563. Flowmeter twins
A564. Ice flaker
A565. Room air sterilizer

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573. Laundry equipment
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575. Sterilizers brochure
576. Surgical instruments
577. Dishwashing booklet
578. Procedure manual
579. Plastic tubing booklet
580. Moniliasis film

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503	513	522	531	541	550	559	572	581	590	597C
504	514	523	532	542	551	A560	573	582	591	597D
505	515	524	533	543	552	A561	574	583	592	597E
506	516	525	534	544	553	A562	575	584	593	597F
507	517	526	535	545	554	A563	576	585	594	
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514. Clinical audiometer
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517. Cleaner concentrate
518. Portable sitz bath
519. Suction machine
520. Vinyl plastic dressing
521. Melamine tray
522. Pillow speaker jacket
523. Blood-shipping container
524. Catheter holder
525. Hot-chocolate mix
526. Surgical light
527. Patient handler
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529. **Oven-sterilizer**
530. **Ultrasonic unit**
531. Bedside lamp
532. Presterilized needles
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535. Lighting fixture
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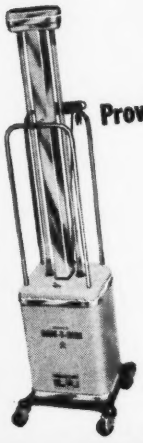

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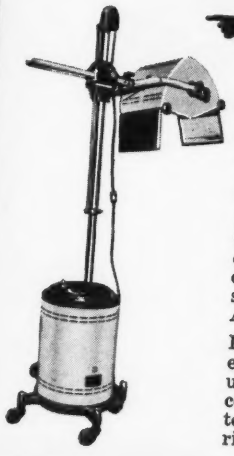

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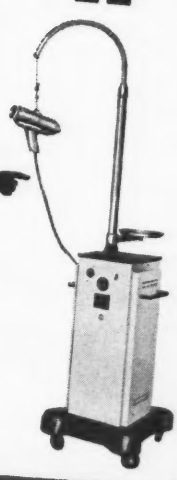

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Medical Education Fund Sets National Goal

The National Fund for Medical Education has a national goal of $700,000 in "new money" for the benefit of teaching budgets in all the country's fully accredited medical schools.

This sum, added to regular annual contributions, would qualify the fund to receive $2,000,000 from the Ford Foundation, Merle A. Gulick, chairman of the fund's Greater New York committee, and Chase Mellen Jr., executive vice-president, told 15 representatives of industry at a luncheon opening the current New York area fund-raising campaign recently.

Eighty-two medical schools now receive an average of $20,000 annually from the fund to supplement faculty salaries.

United Hospital Fund Changes Location

The United Hospital Fund of New York has announced its new location, at 3 E. 54th St., New York 22, N.Y.

Looking for help in setting up standard disinfection procedures?

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Offer Scholarships in Special Library Field

Two $700 scholarships to be granted for the academic year 1957-58 for graduate study in librarianship have been announced by the Scholarship and Student Loan Fund committee, Special Libraries Association.

Applicants must be college graduates in need of financial assistance to obtain a degree at an accredited library school.

Details of eligibility and application blanks may be obtained from the executive secretary, Special libraries Association, 31 E. Tenth St., New York 3, N.Y. Deadline for applications is March 1, 1957.

Hospital Administrators Elect Officers

A. J. Swanson, chairman, Ontario Hospital Service Commission, Toronto, was installed as president of the American College of Hospital Administrators, at its 22nd annual meeting in Chicago, September 15-18. He succeeded J. Dewey Lutes.

Other officers elected for the coming year are: president-elect, Frank Groner, administrator, Baptist Memorial Hospital, Memphis, Tenn.; first vice-president, Anthony W. Eckert, director, Perth Amboy (N.J.) General Hospital; second vice-president, Elmina Snow, administrator, Emerson Hospital, Concord, Mass.

VA Medical Advisory Group Appoints Four Members

Four new members have accepted appointments to the VA Special Medical Advisory Group.

They are: Charles D. Shields, M.D., professor and director, department of physical medicine and rehabilitation, Georgetown University, Washington, D.C.; Howard P. Rome, M.D., department of psychiatry, Mayo Clinic, Rochester, Minn.; Shields Warren, M.D., Cancer Research Institute, New England Deaconess Hospital, Boston; and Mrs. Marion Sheahan Bailey, associate general director, National League for Nursing, New York City.

Pennsylvania Hospital Changes Name

The Kalkhof Hospital and Clinic Inc., 3805 Field St., Lawrence Park-Erie, Pa., has changed its name to M.D. General Hospital and Clinic, Inc.

Thomas C. Kalkhof, M.D., is director.

Practical Application of Electrophoresis In Diagnosis

By Bess G. Osgood, Ph.D.*

• Electrophoresis as a research and investigational tool has been used to advantage in a variety of problems, chiefly to separate substances which are very much alike and which resist efforts to separate them by chemical means. Clinical use of electrophoresis is fairly recent and has been limited in its application.

Electrophoresis is the differential migration of charged particles in solution under the influence of an electric current. It can be performed in a solution (moving boundary electrophoresis) or in a solution supported by a solid medium such as starch or paper (zone electrophoresis). We shall discuss zone electrophoresis on filter paper (paper electrophoresis).

The preparation of electrophoretograms—the papers upon which the substances are separated and fixed — is within the scope of all laboratories. Analysis of the separated components is the stumbling block upon which so many of us have stubbed our toes.

PREPARATION OF ELECTROPHORETOGRAMS

The apparatus may be a simple "do-it-yourself" affair, or a more elaborate (and expensive) piece of equipment. Common to all instruments are:

(1) A support for the paper
(2) Two electrolyte (buffer) chambers with electrodes
(3) A source of direct electric current.

The paper support may be the ridgepole type, with the paper suspended in an inverted V; the horizontal type, with free-hanging paper; or the sandwich type, with the paper sandwiched between two glass plates. The electrolyte solution, which is usually a buffer of definite composition and pH, allows the passage of the current and is responsible also for the direction in which the particles migrate, by virtue of its pH.

The filter paper is moistened with buffer. A small amount of the solution to be analyzed is placed at the proper spot on the paper, and the current is allowed to flow until the separation of the fractions is reasonably complete. Each fraction has a characteristic mobility, and under the proper conditions all of the fractions are separated into zones. The papers are dried, and treated in some way to render the components visible or otherwise measurable.

Table I
Analysis of Some Clinical Substances of Clinical Interest

Substance	Method of Analysis
Hemoglobins	Visual examination
Serum proteins, lipoproteins and protein-bound carbohydrates	Dyeing, and scanning or elution
Serum cholesterol	Elution, and usual tests
Nucleic acids	Fluorescence under ultraviolet light
Enzymes	Biological activity
Antibiotics	Reactivity
Toxins	Reactivity
Protein-bound radioactive elements	Radioactivity
Phosphorus	
Iron	
Iodine	
Sulfur	
Carbon	

ANALYSIS OF ELECTROPHORETOGRAMS

Visual inspection of electrophoretograms (or electropherograms or ionograms, as they are also called) is satisfactory for some substances, but in most cases the quantitative determination of the separated components is desirable. It is in this field that we experience most of our difficulty.

Table I lists a few of the many substances of clinical interest that have been analyzed, and the methods of their analysis. *Elution* refers to the technic of cutting the strip into segments, dissolving the dye or fraction from each segment, and determining its concentration by chemical means. The method of *scanning* consists of passing the colored strips beneath a photoelectric cell and recording the optical densities at various distances along the strip. The instrument used for scanning is called a densitometer.

CLINICAL APPLICATIONS

Over three-fourths of the papers published on paper electrophoresis deal with proteins or protein derivatives. Of special interest to the routine clinical laboratory is the analysis of abnormal hemoglobins, the proteins of serum, urine, and spinal fluid, and the lipoproteins and glycoproteins of serum.

Abnormal Hemoglobins. It has been known for some time that the abnormality of the hemoglobin in sickle-cell disease resides in the globin (protein) part of the molecule. The hemoglobin in this disease, called Hemoglobin S, migrates more slowly on paper than normal adult hemoglobin, Hemoglobin A, at a pH of 8.6 with a barbiturate buffer.

Another abnormal type, Hemoglobin C. migrates even more slowly

(Continued on next page)

*Chief biochemist, South Bend (Ind.) Medical Foundation. Presented at the Conference on Laboratory Service of the Tri-State Hospital Assembly, Chicago, May 1, 1956.

(Figure 1). Hemoglobin F, fetal hemoglobin, migrates at almost the same speed as Hemoglobin A, and is impossible to separate from A by the usual technics. Several other types of abnormal hemoglobin have been detected by paper electrophoresis, but they are less common in this country than the abovementioned types.[13]

Technically the electrophoresis of hemoglobins is very simple. Red cells washed free of plasma proteins are hemolyzed with distilled water, and the hemoglobin solution subjected to electrophoretic analysis. Visual inspection of the patterns is sufficient to give us our information.

Proteins of Serum, Urine, and Spinal Fluid. By far the greatest amount of study has been done on the serum proteins. Changes in the various components have been shown to occur in many diseases, and a simple rapid method for their separation and analysis would be a boon both to the clinician and to the analyst. Unfortunately, paper electrophoretic analysis of serum proteins is not easy or rapid enough to be classed as a simple method. The electrophoretograms are easily prepared. It is their quantitation that is troublesome.

Serum — from 0.002 to 0.01 ml. — is used usually without preliminary treatment. Urine and spinal fluid are concentrated, usually by dialysis in a cellophane bag against a concentrated solution of dextran or polyvinyl pyrrolidone. After the proteins are separated and the paper is dried, the proteins are dyed to render them visible.

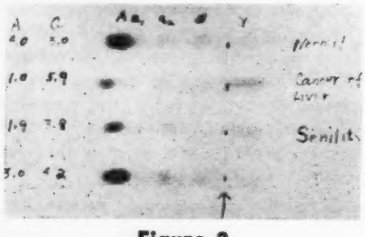


Figure 2

Electrophoretogram of human serum proteins. Current of 350 volts for 3½ hours, Whatman 3MM filter paper, Azocarmine B dye. The last serum is from a patient whose illness was not diagnosed. The A/G ratios at the left were determined chemically.

Figure 2 shows a developed electrophoretogram of several sera. The fractions are albumin and the various globulins, named alpha 1, alpha 2, beta and gamma globulins in the order of their mobility. The fibrinogen of plasma would appear between the beta and gamma globulins.

The albumin fractions are more intensely stained than the globulins. This is characteristic of all of the protein dyes used, and represents one of the errors of analysis.

In many cases alterations in the protein pattern are not great enough to be readily detected by visual inspection. Elution and photometric determination of the dye bound by each fraction is a precise but tedious procedure, not suited to the routine laboratory. Scanning the paper strip gives a series of values which when plotted against the distance of migration gives a curve which looks familiar, since it resembles the patterns obtained in free electrophoresis.

Figure 3 illustrates such a pattern for normal serum. The areas enclosed by the peaks represent the relative concentration of dye and thus of the protein for that area. The areas for each fraction are measured by planimetry. These areas are totaled, and the percentage of the total area occupied by each fraction is then calculated. The absolute protein concentration must be determined chemically.

The manual plotting, diagramming, and planimetry of protein patterns is as laborious as the elution technic. Several companies have developed instruments for rendering much of this work automatic. The finest suggestion which I have seen, and one which seems to me to bring the analysis of protein patterns into the realm of the routine laboratory, is this:

Using a densitometer with a slit width of exactly 2 mm., one reads the optical density at 2-mm. intervals along the paper strip. The sum of the optical density values for any fraction is then a measure of the relative construction of that fraction. The percent of each component can be readily determined without diagramming.[10]

Visual inspection is usually sufficient for urinary proteins. Bence-Jones proteins are found in the beta or gamma position of serum patterns,

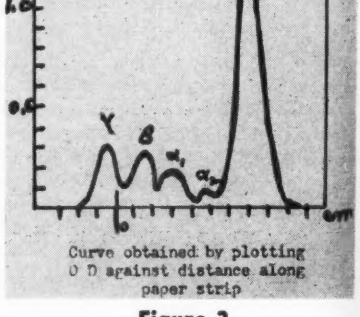


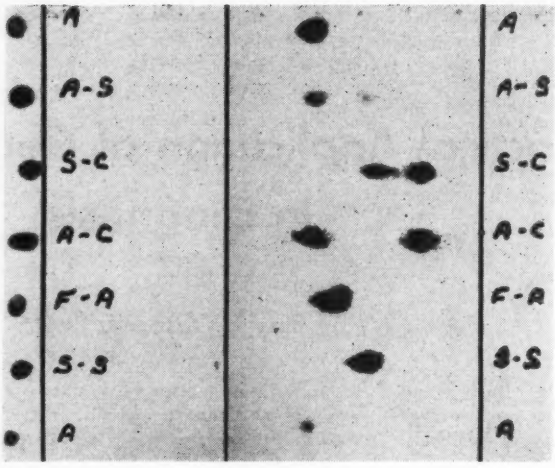
Figure 3

Scanning diagram of a normal serum. The alpha 1 and alpha 2 globulin labels have been reversed. The spot marked O on the horizontal axis is the point of orgin.

while the albumin behaves as serum albumin.[11] Lipoprotein patterns are detected by staining the paper with fat-soluble dyes. Gross changes can usually be determined by visual inspection (Figure 4). Lipoprotein analysis may become important in the routine laboratory in the not too distant future. (1, 2, 6, 9.) Glycoproteins and mucoproteins are stained by Schiff's reagent. Work on these fractions is still in the investigational stage.

SUMMARY AND CONCLUSIONS

There are many sources of error



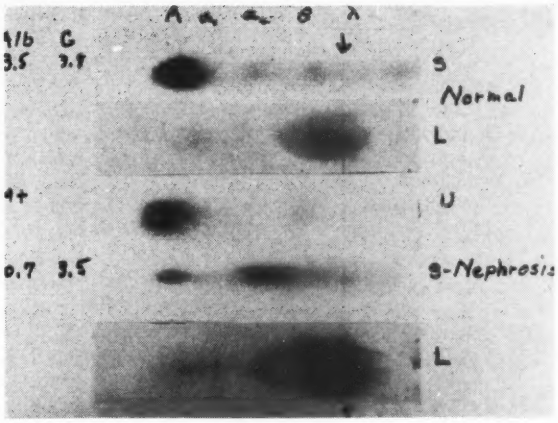
Filter paper analysis of some abnormal hemoglobins. At the left the positions after one hour of migration, at the right after five hours of migration. Sandwich type of paper support 0.06 M barbiturate buffer of pH 8.6 450 volts. The direction of migration is to the left. The orgin is the line just left of the identifying letter.

Figure 1

inherent in the method. For a discussion of these and other factors, the reader is referred to several general and review articles. (3, 4, 5, 7, 8, 12.) However, if each step of the procedure is carefully standardized and this standardization rigidly adhered to, patterns can be obtained routinely which are reproducible and quite satisfactory for clinical purposes.

Of course each laboratory should run a series of normal fluids to establish the range of values for each fraction, and the degree of reproducibility. A normal specimen should be run with each set of unknowns.

What can we in the routine clinical laboratory gain from this new technic? Are its sensitivity, reproducibility, and versatility sufficiently superior to the chemical analysis of these fractions to justify its routine use? There is considerable difference of opinion among authors of clinical papers. Certainly more detailed information is gained by analysis of all the serum protein fractions than by an A/G ratio. Yet we still need a chemical method for determining the absolute protein concentration. And the lapse of time required for a complete serum protein analysis is actually greater than for the chemical method, especially with the types of apparatus requiring an overnight run for the separation of the proteins.



Proteins and lipoproteins of normal and nephrotic human sera. S=serum proteins, L=lipoproteins, U=urine proteins. The A/G values were determined chemically. Proteins stained with Azocarmine B, lipoproteins with Oil Red O. Migration for 3½ hours with a current of 350 volts.

Figure 4

When visual inspection yields the desired information, the method is of great value. If quantitation is desired, one should decide for himself.

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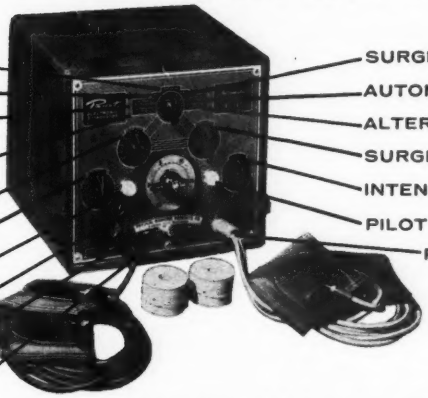

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*General and review articles.

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A radioactive-iodine-tagged material, Diodrast, is injected intravenously. Scintillation counters, placed over the kidney areas, measure radioactivity and thus indicate rates of uptake and excretion of test material by the kidneys.

Electrically-recorded data (renograms) accurately indicate each kidney's blood supply, function, and whether the upper urinary passages are open or obstructed by stones, tumors, or infections. Certain kidney abnormalities have characteristic renograms.

The study was a cooperative effort of the UCLA Atomic Energy project, Medical School, and the VA Center.

BOOK CORNER

(Continued from page 80)

This is the second of two manuals on the cause and treatment of psychological disorders in civil disasters, prepared at the suggestion of the Federal Civil Defense Administration.

For every 100 physically-injured persons, the manual points out, there will be 10 to 25 who suffer from temporary psychological upsets.

Normal reactions to disaster and the three degrees of disaster fatigue are described, and the importance of prompt treatment to meet the emotional needs of these patients is emphasized.

CENTRAL SUPPLY YEARBOOK FROM HOSPITAL TOPICS. Volume I. Chicago: HOSPITAL TOPICS. 1956. 108 pages. $1.50.

The CENTRAL SUPPLY YEARBOOK is a compilation of practical material from HOSPITAL TOPICS. It is geared to aid the central supply supervisor and her staff to improve and expedite the services of this department toward the goal of better care.

The 108 pages of carefully selected material start with a complete series concerned with the planning, equipping, and work flow of a central supply and the processing of materials, by an architect and a nurse.

Articles are included on sterilization, inservice programs, work simplification and other major problems encountered in central supply, by recognized authorities in these specialized fields. Among the authors: Margaret K. Schafer, R.N., Frederick Markus and Jean Christie, R.N., Edna Prickett, R.N., Betsey Carrol, R.N., and Velma Chandler, Ph.D.

SILENT SPOKESMAN—an Aid to the Speechless.

By Wayland W. Lessing. Chicago: HOSPITAL TOPICS. 1956, 36 pages, $1.50.

This is a "communication book" that will greatly allay the frustrations of the patient suffering from aphasia (loss of speech) and those who are taking care of him.

The book contains 70 "key pictures" of common objects, and many words and sentences which have been carefully selected to cover nearly all the patient's daily needs.

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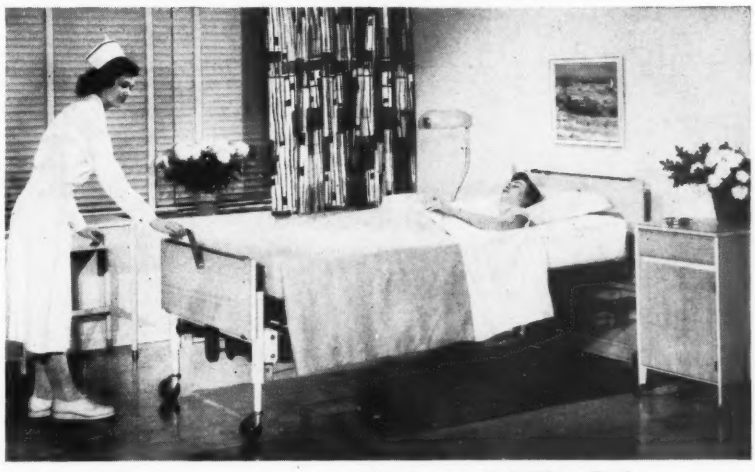

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Safety Sides—A New Safety Measure

by Alice L. Price, R. N., M. A.
author of "The Art, Science and Spirit of Nursing"

This Procedure Manual explains in detail how to effectively use Safety Sides to prevent bed falls and to avoid serious injury to patients. Copies for Student Nurses and for the Graduate Nurse Staff will be sent on request.

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*Talbot, N. B., Crawford, J. D., and Butler, A. M., "Homeostatic Limits to Safe Parenteral Therapy." New Engl. J. Med., 248, 1100 (1953).

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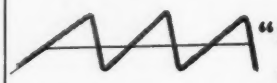

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A. O. R. N. Group Formed in Boise

Operating room nurses in the Boise (Ida.) area have organized a new A.O.R.N. group. Members are shown above at a recent gathering.

Right: Officers of the newly formed group are (l. to r.): Mrs. Elizabeth Hughes, program committee; Mrs. Louise Haney, secretary; Glenda Raftree, program committee; Mrs. Barbara Morgan, president, and Mrs. Patricia Harting, vice-president.

42nd Clinical Congress

American College of Surgeons

Final attendance at the American College of Surgeons Clinical Congress, held recently in San Francisco, was 8,864. Abstracts of selected papers follow.

Ileocolic Valve Substituted For 'Cardio-Esophageal Sphincter'

No Evidence of Inflammation Segment Resistant to Acid-Peptic Digestion

Interposition of a segment of ileocolon with its blood and nerve supply intact after resection of the terminal esophagus and esophagogastric junction was carried out on 16 dogs. Comparative studies were made on a series of dogs on which jejunal interposition procedures (Merendino) had been performed 18 to 24 months previously.

After postoperative recovery, competency of the ileocolic valves was determined by roentgenological examination of the stomach and esophagus with the animal in the Trendelenberg position. The animals were then placed on daily subcutaneous injections of histamine phosphate in oil and beeswax (Code and Varco). Cross and microscopic examinations were made of all specimens.

Under histamine stimulation no evidence of inflammation was found proximal to the ileocolic valve, and the small colonic segment distal to the valve was more resistant to acid-peptic digestion than either the stomach or duodenum.—**John S. Najarian, M.D., Chauncey D. Buster, M.D., Dwight H. Murray, Jr., M.D., and Orville F. Grimes, M.D.,** Surgical Research Laboratories, University of California School of Medicine, San Francisco. Calif.

Enterostomy Revived in Procedure For Small Bowel Obstruction

Report 'Gratifying Increase' in Survivors

A gratifying increase in survivors has resulted following the revival of enterostomy as a part of a Mikulicz type two-stage procedure for the management of small bowel obstruction in infants.

In 186 cases at Boston Children's Hospital in the past seven years, detailed nutritional data were charted, spot observations on gastrointestinal function and extra-renal losses made, and a 12-day metabolic balance performed on an infant with congenital ileac atresia. Metabolic studies on other infant surgical patients provide material for comparison. The cases are:

Congenital atresia (jejunum, ileum, colon)	50
Meconium ileus	40
Intussusception	30
Congenital stenosis	12
Volvulus with and without malrotation	12
Perforated Meckel's diverticulum	12
Miscellaneous	30

Although marked variations exist, an average composite successful case might show: (a) admission weight deficit of 12 per cent; (b) parenteral intake six days overlapping oral three days; (c) enterostomy output volume plateau at 250 cc. by fifth day; and (d) only mild physiological disturbance by operative closure on ninth day, with subsequent retention curve steep from addition of growth and convalescent rates.

Extra-renal loss analyses have re-emphasized the value of early oral feeding and frequent weighing of the patient.—**William R. Richardson, M.D.,** and **Robert E. Gross, M.D.,** Department of Surgery, Children's Medical Center and Harvard Medical School, Boston.

Method for Renal Substitution Utilizes Closed Cellophane Tube

Find No Significant Change In Fluid Volume or Weight

In a method for renal substitution utilizing intraintestinal dialysis, a closed cellophane tube made from 20/32 inch dialyzing tubing is introduced into the small intestine. Using suitable connections, a dialyzing fluid of appropriate electrolyte and osmolar concentration is perfused through the lumen of the tubing.

Twenty-four nephrectomized dogs and one terminal uremic patient have been studied for varying periods by this and other methods of renal substitution in a comparative evaluation. A metabolic balance technic has included analysis of serum and dialysate fluids for sodium, potassium, calcium, magnesium, chloride, bicarbonate, phosphate, nonprotein nitrogen, urea nitrogen, glucose, and pH. Exchange rates of radiosodium, radiopotassium, and heavy water between the blood and the cellophane tube contents have been measured in both directions.

Results thus far indicate that potassium, nonprotein nitrogen, urea, and creatinine may be removed selectively from the body by enterodialysis without significant change in fluid volume, body weight, or undesirable electrolyte alterations.

In the patient, removal of potassium at a rate of 36 mEq. per day and nitrogen at a rate of 10.1 grams per day by enterodialysis is in excess of the minimum

daily dietary requirement.—**Paul R. Schloerb, M.D.,** Department of Surgery, University of Kansas School of Medicine, and Research Laboratory and Radioisotope Service, Kansas City (Kan.) VA Hospital.

Find Open Thoracotomy Not Cause For Increased Pulmonary Ventilation

Compression of Lung
Believed Significant Factor

The assumption that an open thoracotomy per se requires increased pulmonary ventilation is not borne out by our studies. Compression of the lung is apparently the significant factor.

Patients were studied preoperatively and during operation. A constant CO_2 tension of end-expired gas was monitored by a Liston-Becker analyzer using Collier's technic and checked with periodic arterial blood analyses. The amount of ventilation required to maintain a constant, normal CO_2 tension of the arterial blood was measured while the patient was (1) conscious, (2) under anesthesia with the chest closed, (3) with the chest open but the lung normally expanded, and (4) with the chest open and the lung compressed.

In the anesthetized state the required ventilation was greater than in the conscious state. Opening the chest had no effect upon the required ventilation, if the lung was normally expanded. Compression of the lung always necessitated an increase in the required ventilation.—**Thomas F. Nealon, Jr., M.D., Joyce E. Price, R.N.,** and **John H. Gibbon, Jr., M.D.,** Jefferson Medical College, Philadelphia.

Modify Original Method Of Left-Heart Catheterization

New Method Used to Evaluate
Patients for Valvuloplasty

A modified method of left-heart catheterization promises to be a valuable diagnostic aid for the cardiologist and cardiac surgeon.

The original method reported by Bjork, Blakemore and Malmstrom has been modified to obtain simultaneous pressure measurements from the left auricle, left ventricle, and ascending aorta. From the measurements of pressure gradient and the central mixing volumes determined by the injection of radioactive potassium into the left atrium, left ventricle, and aorta, a quantitative estimation of the degree of stenosis and inefficiency of the mitral and aortic valve can be made.

Thirty-seven seriously ill cardiac patients have been studied using the new technic. In all these patients the relative degree of valvular stenosis and insufficiency remained obscure after the conventional diagnostic procedures. The method is now being used with increasing frequency for evaluation of patients under consideration for valvuloplasty.

Serious complications have been few, but one fatality has occurred in our group of patients.—**William S. Blakemore, M.D., Truman G. Schnabel, Jr., M.D., Peter T. Kuo, M.D., Hadley L. Conn, M.D.,** and **Stephen Langfeld, M.D.,** Harrison Department of Surgical Research, and Edwin B. Robinette Foundation Medical Clinic, Hospital of the University of Pennsylvania, Philadelphia.

Variety of Prosthetic Aortic Valves Tried in Dogs

No Satisfactory Valve Found

We have designed and placed a variety of plastic prosthetic aortic valves in more than 40 dogs during an 18-month period.

We have used a conical "dixie cup," a round bottom valve designed to minimize clotting, an open end "wind sock" valve protruding into the aorta, a ball valve, and both bicuspid and tricuspid flap valves. Each has its own peculiarities and difficulties in insertion.

Both suture fixation and fixation within a plastic ring have been employed.

Proper oxygenation of the myocardium during open operation about the coronary ostia has produced a number of problems regarding coronary perfusion and air embolism. We have utilized both coronary catheter perfusion with a pump-oxygenator and operation on the empty heart in arrest.

A satisfactory valve is not yet forthcoming.—**William G. Malette, M.D., William B. Summers, M.D.,** and **Ben Eiseman, M.D., F.A.C.S.,** Denver, Department of Surgery, University of Colorado School of Medicine and VA Hospital.

Prosthetic Valve Well Tolerated For Aortic and Mitral Stenosis

Made of Nylon-Covered Elgiloy Frame

A prosthetic valve made of a nylon-covered Elgiloy frame has been used in animals for 65 mitral and 40 aortic prostheses. Studies have been carried out at regular intervals up to two and one-half years.

The prosthesis for both the aortic and mitral valve is appropriate for its location—circular for the aortic and diamond-shaped for the mitral area.

A technic for inserting and securing this type of valve with unipoint fixation has been worked out for both the mitral and aortic areas.

The prosthesis is well tolerated within the heart, has directional motion, and is valvulogenic in that it soon becomes covered with living tissue. The normal directional flow of blood, including coronary flow, is not impeded. In addition, there is no interference with the clotting mechanism or red cell life. There has been no embolization of the prosthesis itself, nor has any clot formed on the valve to embolize.—**James H. Wible, M.D., Lyle F. Jacobson, M.D., Prescott Jordan, Jr., M.D., F.A.C.S.,** and **Charles G. Johnston, M.D., F.A.C.S.,** Detroit, Michigan, Wayne University College of Medicine.

Experiments Test How Much Occlusion Heart Can Stand

One Animal Withstood Complete
Coronary Arterial Occlusion

Our experiments were designed to discover the degree of total arterial occlusion which the normal canine and porcine heart could withstand.

A small stainless steel spring clamp with jaws separated by surgical gut was used to occlude the coronary arteries. When placed in the tissues, the gut is slowly absorbed, allowing the clamp to close around a coronary artery. These clamps have been placed on the coronary arteries of 29 dogs and six pigs. The left anterior de-

(Continued on next page)

scending, the left circumflex, the left septal branch, and the right coronary arteries have been subjected to occlusion.

The animals have been observed with postoperative electrocardiograms and X-rays for periods up to 16 months. At autopsy the degree of obstruction, presence of inter-coronary arterial anastamoses, as well as the gross and microscopic appearance of the heart, were recorded.

The results show that during the period of approximately one month in which these clamps are closing, the heart is stimulated to develop intercoronary anastamoses. A much greater degree of coronary arterial occlusion can thus be tolerated than when acute ligation is performed. At least one animal has withstood bilateral complete coronary arterial occlusion, and several survived over 50 percent occlusion without infarction—**Charles G. Neumann, M.D., F.A.C.S., Albert B. Lowenfels, M.D., William H. Wade, M.D., Jerrold von Wedel, M.D., F.A.C.S., Jere W. Lord, Jr., M.D., F.A.C.S., and J. William Hinton, M.D.,** Department of Surgery, New York Postgraduate Medical School, New York City.

Electronic Respirator Demonstrates Superiority to Other Models

Suggests Possibility of Continuous Control of Respiration

A new electronic respirator has demonstrated a definite superiority over older respirators and opens up the possibility of continuous control of respiration by blood pH or oxygen saturation.

An electronic interval timer was connected to two solenoid valves. Air under pressure was then channeled through an air reduction valve, positive pressure reservoir, intake solenoid valve, and one-way valve to the endotracheal tube of a dog.

The expiratory arm of the Y-tube was connected, in series, to a one-way valve, outflow solenoid valve, negative pressure reservoir, and vacuum pump. The size of the reservoirs was then changed until physiological respiratory curves were attained.

Highly sensitive pressure differential switches were connected to tubes inserted on each side of the one-way valves and also to the interval timer. These were then adjusted so that, at reasonable pressures, the animal could trigger the pressure switch and gain assistance for his respiratory effort.—**Charles E. Turbak, M.D., Robert B. Benjamin, M.D., Louis M. Levy, B.S., and F. John Lewis, M.D.,** Department of Surgery, Ancker Hospital Surgical Research Laboratory, St. Paul, Minn., and University of Minnesota Medical School, Minneapolis.

CO_2 Measures Effect on Utilization Of Rate of Food Administration

Increases in Output Roughly Proportional to Administration Rate

Alterations in the production of carbon dioxide, the major end-product from food combustion, have been used to measure the effects of rate of administration on foodstuff utilization.

A portable gas exchange apparatus has been employed allowing bedside measurement of carbon dioxide production during variable rate intragastric tube feeding and variable rate intravenous feeding. Comparisons are made with the fasting state and when eating three normal meals.

No increase in carbon dioxide production above basal, fasting levels, could be detected when foodstuffs were provided at a uniform rate under 40 calories an hour by either intravenous or oral route. Uniform administration of oral or intravenous foodstuffs from 40 to 300 calories an hour yielded increases in carbon dioxide output roughly proportional to the rate of administration.

Oral feeding above 300 calories an hour did not produce prompt, proportional increases in carbon dioxide production but did result in a prolonged response assumed to be the result of the gastrointestinal tract serving as a reservoir.—**John M. Kinney, M.D., William G. Hammond, M.D., Banks Anderson, Jr.,** and **Elliott V. Miller, M.D.,** Department of Surgery, Harvard Medical School, Peter Bent Brigham Hospital, Boston.

Osmotic Diuretic Helpful In Severe Hyponatremia

Produces Large Volumes Of Salt-Poor Urine

Mannitol, a patent osmotic diuretic, acts to produce large volumes of salt-poor urine in the presence of postoperative antidiuresis and increased adrenocortical activity. This action has been utilized in a series of patients who developed severe hyponatremia and in whom hypertonic saline therapy was considered inadvisable.

Hypertonic Mannitol solutions were infused slowly to prevent deleterious increases in extracellular fluid volume. During and after the infusions, urine volumes increased markedly without commensurate increases in sodium output. Serum sodium concentrations rose eight to 10 meq./L., and clinical manifestations of hyponatremia and hypotonicity regressed.

Postoperative hyponatremia of marked degree not infrequently occurs after cardiac valvular surgery or following major operative procedures performed upon previously depleted individuals. Patients with chronic congestive heart failure or severe liver disease are also prone to develop dangerously low serum sodium concentrations in the postoperative period. Hypertonic saline infusions, although useful in "deficit hyponatremia," are usually contraindicated, since further expansion of extracellular fluid volume may lead to severe pulmonary edema.—**William G. Hammond, M.D., Rodman D. Carter, M.D., John M. Davis, M.B., M. Chir.,** and **Francis D. Moore, M.D.,** Department of Surgery, Harvard Medical School, Peter Bent Brigham Hospital, Boston.

Intravenous Infusion Favored In Care of Acutely Injured

Air Embolism a Constant Hazard When Blood Is Being Replaced

While preparing the acutely shocked patient for emergency surgery, one must assume that the injured man is being continuously injured, as any impairment of the circulation results in injury to the whole body.

Surgery and anesthesia represent additional injuries, and deficiencies in circulating blood volume should be corrected before either is started.

Hemorrhage from wounds of the extremities is relatively easy to control. Definitive hemostasis with a clamp is preferred to use of a tourniquet.

We feel that intra-arterial infusions have no place in the management of the acutely injured men. Rapid intravenous infusion has all the advantages and none of the disadvantages.

When blood is being pumped into a patient to replace rapid blood loss, the danger of air embolism is ever present. No matter how well alerted the personnel in a busy emergency ward, pressure of responsibility will divert their attention, and a two-bottle system of infusion should be used to avert tragedy from this source.

In treating the injured male, transfusion with Type O blood without Rh typing is feasible. This is not so for the female.

The injured alcoholic presents cause for added concern. He is very sensitive to many drugs, changes of position, etc., and more sensitive to blood volume deficiencies than the man with normal vascular tone. He may respond quickly to the administration of saline.

The injured patient should be moved as little as possible, and his position changed as little as possible until his blood-volume deficiency is corrected.

In penetrating wounds of the chest with positive-pressure pneumothorax, a thoracentesis tube in the chest will often restore blood pressure to normal limits without transfusion. Patients with ruptured abdominal viscera respond only moderately to transfusion. Here, surgery becomes part of the treatment of shock—but only under local anesthesia. A patient in severe shock from infection who does not respond to transfusion will be killed by surgery. On rare occasions, surgery under local anesthesia may be successful, but extreme caution should be used in considering this group of patients for surgery.

The patient with infection of the leg in severe shock can be treated by application of a tourniquet and ice to isolate the wound from the body. When blood is not available, expanders are useful. In any event, the blood volume must be maintained, because there is a limit to how rapidly and how much the hematocrit can be dropped.

In treatment of mass casualties, one study showed that 80 percent required less than four units of blood; 11 percent more than five liters of blood or Dextran. The supply of blood under the latter circumstances might be expanded by alternating one agent with the other.

In the shocked patient with deficient circulation, changes in gas tension and electrolytes build up at a rapid rate and must be corrected. A 20 to 25 percent drop in blood pressure is usually corrected by the administration of one liter of blood; a 40 to 45 percent drop represents profound shock, and two or more liters are necessary. In any instance, efforts should be made to stop the bleeding, replace the loss, and correct the deficiency that minimizes the efficiency of the circulation.—**John M. Howard, M.D., Atlanta, Ga.**

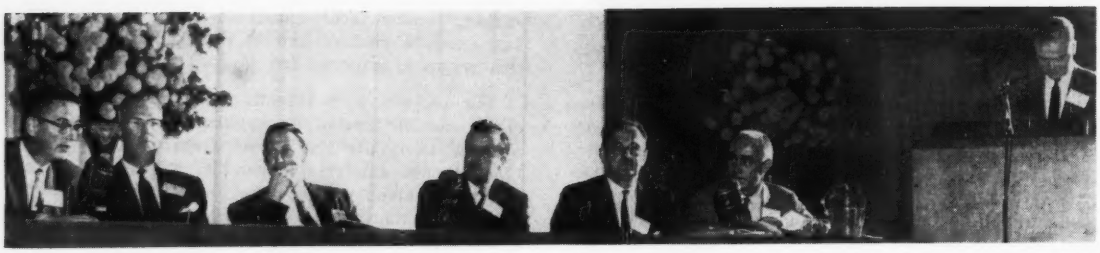
(Continued on next page)

Outstanding senior medical students attended the congress at ACS expense, under a program tried this year for the first time. Representatives of 16 schools, chosen by their fellow students, were at the San Francisco meeting. Fellows of the College acted as advisors to the students, meeting daily with them to help them decide which sessions to attend, and after the sessions as well to discuss material presented.

The nation's medical schools will participate in the program in rotation—depending on geographic location of the congress every year. Next year's congress will be in Atlantic City.

Standing (l. to r.): Vernon Leroy Stafford, College of Medical Evangelists; Thomas G. Daniel, University of Oklahoma School of Medicine; Berkeley S. Eichel, University of Southern California School of Medicine; Robert D. Bloodwell, Baylor University College of Medicine; Eugene S. Maier, University of Utah College of Medicine; R. E. Ransmeier, University of Colorado School of Medicine; Daniel B. Konrad, University of British Columbia Faculty of Medicine; Frank Parker, University of Washington School of Medicine, and Robert E. Quick, University of Nebraska College of Medicine.

Seated (l. to r.): Robert J. Pierce, Southwestern Medical School of the University of Texas; D. W. Irving, University of Alberta Faculty of Medicine; Pierre W. Keitges, Creighton School of Medicine; Edward B. Cavanaugh, University of California School of Medicine; John A. Blakeley, University of Saskatchewan College of Medicine; Thomas C. Tips, University of Texas School of Medicine, and Donald B. Bowman, University of Oregon Medical School.



Shown above, during the Cine Clinic panel on hernia, are (l. to r.): Henry N. Harkins, M.D., Seattle, Wash.; Walter C. MacKenzie, M.D., Edmonton, Alberta; Colin C. Ferguson, M.D., Winnipeg, Ont.; Peter V. Moulder, M.D., Chicago; Leo M. Zimmerman, M.D., Chicago; John T. Reynolds, M.D., Chicago; and Earle B. Mahoney, M.D., Rochester, N. Y.

American College of Surgeons Continued

Plasma Volume Expanders Useful In Treating Hypovolemic Shock

No Evidence That PVP
Is Carcinogenic in Man

Since plasma volume expanders have no oxygen-carrying power and do not aid clotting or fight infection, they cannot be called blood substitutes. Their advantages are long shelf life, ease and certainty of sterilization, including destruction of the hepatitis virus, cheapness of manufacture, and possibility of rapid production in time of need.

These substances should never be depended upon in lieu of adequate hemostasis. They are of use in treatment of hypovolemic shock. All three (gelatin, PVP, and Dextran), are effective, with Dextran apparently the most popular, despite the fact that it prolongs bleeding time.

Polyvinylpyrolidone is essentially a liquid plastic, and in some experimental animals, some of the plastics have appeared to be cancerogenic. In some species, studies of PVP have shown it to be carcinogenic. Concern for the carcinogenic properties of PVP resulted in an investigation of German records, but no evidence of carcinogenicity in man was accrued.

It is not completely excreted from the body; only 65 percent is recovered. Liver studies suggest prolonged storage in the body. **Jonathan E. Rhoads, M.D.**, Professor of Surgery and Surgical Research, University of Pennsylvania School of Medicine, Philadelphia.

Surgeon Should Question Need for Every Biopsy

Lesion May Be Traumatized
By Much Handling at Surgery

Principles governing tumor biopsy differ for each organ and each situation. It is often better policy to excise a tumor than to incise it with the attendant risk in the latter of implanting tumor cells along the tract of incision.

The surgeon should question the wisdom of every biopsy. He should question its need for diagnosis; its location in relation to tumor and advantage to the patient of incisional biopsy over excisional.

Cancer of the colon should be excised with care to prevent dissemination of tumor cells throughout the venous system. Too often the lesion itself is traumatized by excessive handling at surgery. In 100 cases of carcinoma of the colon, the cancer-bearing segment was completely isolated by ligation of all its blood vessels and subjected to varying degrees of manipulation. In the 33 which were handled freely, cancer cells were found in the venous blood arising from the tumor in ⅓. In the other 67, which were removed indirectly without undue handling, only 10 had any cancer cells in the venous blood.

There is strong evidence to suggest that recurrences in and about suture lines are due to implants rather than to improper excision. In removing cancer of the colon, it is essential that 10 cm. of bowel below the tumor be removed. If this is impossible, a combined abdominal perineal is necessary for success in curing the patient.

This group of patients requires careful follow-up with sigmoidoscopy and barium enemata at regular intervals for at least two years postoperatively.—**Lauren V. Ackerman, M.D.**, St. Louis; **Rupurt Turnbull, Jr., M.D.**, Cleveland; **John M. Waugh, M.D.**, Rochester, Minn.. **Frank C. Wheelock, Jr., M.D.**, Broookline, Mass.

Phosphorus Used After Surgery Provides Relief in Bone Metastases

Bone Marrow Depression Absent
In Six Patients Studied

Six patients within the last two years have been subjected to bilateral oophorectomy and adrenalectomy and then given radioactive phosphorus. It appears that this combined therapy may afford the patient with osseous metastases from carcinoma of the breast a maximal degree of palliation with little or no undesirable side-effects.

The total dose of P^{32} given to these patients was comparable to that used by Friedell and Storaasli in 1950, when they reported that 83 percent of 12 patients treated with radioactive phosphorus for widespread osseous metastases had significant relief of bone pain.

In their patients, generalized bone marrow depression was a significant complication of the P^{32} therapy and resulted in a 58 percent incidence of thrombocytopenia and leukopenia, and a 75 percent incidence of purpura. None of our six patients developed any clinical signs of bone marrow depression, nor was

there any significant thrombocytopenia or leukopenia.

It was demonstrated in rib segments containing metastatic tumor obtained from three patients that the uptake of P^{32} pre-and postadrenalectomy was significantly greater in the tumor tissue and adjacent bone than in normal bone. The P^{32} excreted in the urine and stool was not affected by adrenalectomy. Striking improvement was noted in most instances in their osseous metastases with areas of recalcification.—**Harvey Krieger, M.D., William E. Abbott, M.D., Willam D. Holden, M.D., Frederick J. Bonte, M.D.,** and **Hymer L. Friedell, M.D.,** Department of Surgery, Western Reserve University School of Medicine and University Hospitals, Cleveland.

Study Role of Hemorrhage In Metabolism After Surgery

Blood Pressure Changes Slight;
Sodium Excretion Kept Decreasing

To understand the relative role of hemorrhage in the production of the metabolic patterns following surgery and trauma, seven healthy young males were bled 11 to 14 percent of their blood volumes while on metabolic balances of sodium, potassium, nitrogen, and water. In addition to body weights and vital signs, suitable blood and urine determinations were made to ascertain the endocrine, hemodynamic, hematologic, and renal changes.

Blood pressure changes following hemorrhage were slight. The process of hemodilution followed roughly an exponential curve, with the hematocrit falling to 80 percent of the initial value in 72 hours. The decrease in red blood cell mass paralleled blood loss, but the change in plasma volume was much less as the result of transcapillary fluid shift and water retention.

Nitrogen and potassium balance changes were inconsequential, but the sodium excretion decreased consistently to produce positive balance. Accompanying this change was a decrease in urinary water output by an amount approximately equal to the blood loss. Thus, zero water balance was maintained.

The slight changes in eosinophile counts, serum corticoids, and urinary steroid and corticoid excretion also seem to indicate that hemorrhage without shock occupies an intermediate position in the spectrum of surgical cases.—**Francis D. Moore, M.D., F.A.C.S., Rodman D. Carter, M.D., Leonard J. Triedman, M.D.,** and **William G. Hammond, M.D.,** Department of Surgery, Harvard Medical School, Peter Bent Brigham Hospital, Boston.

Testosterone Derivative Has Anabolic Effect on Post-Surgery Metabolism

Greater Than Occurs in Patient
Given Extra Nutrients Alone

Because a negative nitrogen balance after surgery such as partial gastrectomy can be diminished by a markedly increased intake of nitrogen, calories, and electrolytes, it would seem that postoperative catabolism may be influenced by nutritive as well as endocrine factors.

In an investigation of the effect of several hormones on the metabolism of surgical patients, Norethandrolone (17-ethyl-17-hydroxynorandrostenone), a recently prepared derivative of testosterone, has been found to have an anabolic effect with apparently minimal androgenic properties.

Above: Daniel C. Elkin, M.D. (r.), formerly Whitehead professor of surgery at Emory University, Ga., was installed as ACS president for the coming year. New president-elect is William L. Estes, Jr., M.D. (l.), consultant in surgery and chief surgeon emeritus, St. Luke's Hospital, Bethlehem, Pa. Dr. Estes will succeed Dr. Elkin at next year's meeting in Atlantic City.

Above: At reception for foreign guests, Evarts Graham, M.D. (r.), professor emeritus, Washington University School of Medicine, St. Louis, and former chairman, ACS board of regents, greets Dr. Ramli, Sumatra, Indonesia, and his wife, Mrs. Ramli Zenaida.

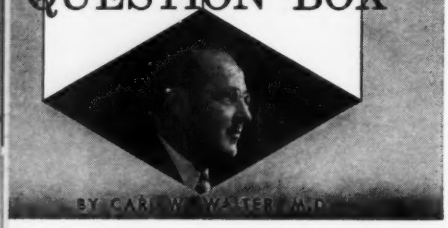
This hormone has been administered to patients who were subjected to either subtotal gastrectomy or to resection of the colon. Metabolic balance data have included total exchangeable sodium and total body water infusions routinely employed after such operations, until oral feedings were resumed.

The other group received nitrogen, calories, and electrolytes in quantities sufficient to approximate the preoperative intake of these substances. Certain patients in each group were given Norethandrolone.

An anabolic effect was demonstrated in patients who received an adequate concomitant intake of nitrogen and calories. This effect was greater than that observed in those who were given extra nutrients alone.

The effect of this hormone has been found qualitatively similar to that of testosterone.—**Helena Gilder, M.D., Edward A. Free, M.D., Donald L. Weeks, Jr., M.D.,** and **John M. Beal, M.D.,** Laboratories for Surgical Research, Department of Surgery, New York Hospital-Cornell Medical Center, New York City.

OR QUESTION BOX



BY CARL W. WALTER, M.D.

Assisted by Dorothy W. Errera, R.N.

Q. In our hospital we do sponge counts by collecting discarded sponges on a towel placed on the floor. When a given number have accumulated, we cover the layer with another towel, etc.

My question is: I disagree on the use of the floor as a working area, because basically we were taught that the floor is the main source of contamination at any time. Therefore, nurses are never allowed to put the soiled bed linen on the floor in any circumstance. If students and graduates see this done in the operating theatre, it refutes the basic principles of nursing care that are taught in the preliminary period.

Please tell me what you think of the use of sponge racks, trays, or buckets. Generally speaking, there is no problem as to the count or the individual receptacles used during a case — but where do you put the sponges while you are counting them?

A. Sponge racks are unsightly, unsanitary, unclean devices which invite air-borne contamination. I agree with your contention that the floor of an operating room must be protected against contamination. An easy way to accomplish the sponge count is to count them directly from the kick pails into waterproof paper bags which are closed when a given number are accumulated. These bags can be kept until the end of the procedure, should a recount be necessary.

Q. I would appreciate your opinion regarding the use of radio in an perating room from a standpoint of explosion hazard, noise and distraction.

A. A properly installed radio should not constitute an explosion hazard. While I agree with you that a radio is distracting, I presume that there are those who enjoy the rhythm and pay little attention to what we might consider noise.

With an anesthetized patient, I presume that the use of the radio becomes the surgeon's choice. If the patient is not anesthetized, however, I would feel that his desire should be paramount.

Q. Can you give me some idea how long an operating table remains sterile under double covers? For example, is an operating table set up six to 12 hours before an operation, covered with double sheets, considered sterile at the end of that time?

A. It is not wise to set up tables preoperatively and leave them unattended. Outbreaks of sepsis have been documented which have been traced to insect contamination of such tables. There is nothing to be gained from such a technic, either in saving of time or material.

Q. We have been asked to disinfect linen from septic cases in the operating room. What is your feeling about this?

A. Attempts to disinfect operating room linen before laundering are unsafe and ineffectual. In the sorting and loading processes, enough bacteria-laden dust and lint would be freed to add considerably to the problem of airborne contamination in the operating room. Proper laundering practice in either the hospital laundry or a commercial laundry exposes the linen to water hot enough to destroy any pathogens present.

Q. Does equipment used for nitrogen mustard therapy need any special treatment?

A. Nitrogen mustards have severe vesicant properties, are very irritating to mucous membranes, and are particularly harmful to the eyes. Hence, all equipment contaminated with the drugs must be handled carefully to prevent skin irritations or burns. The person administering the drug should wear rubber gloves while mixing the solution and rinse the equipment in warm water while still wearing gloves.

After being rinsed, the contaminated syringe and needle are immersed in a solution of 1:1000 sodium hypochlorite for at least an hour before being handled. The infusion set used should be rinsed well with warm water before it is discarded.

Q. How long should a central supply tray be sterilized which contains miscellaneous items such as rubber tubing, syringes, needles, etc?

A. Such a tray can be sterilized for 30 minutes at 250°F. along with other supplies. Care should be taken to rinse the tubing and needles with distilled water immediately before sterilization, leaving a film of moisture which will insure sterilization of the lumen.

Q. Recently our hospital was inspected by a representative from the American Hospital Association. He stated that all ordinary dirt containd B. Subtilis and the dirt could be dried for a certain number of hours, placed in a pack, and sent to the laboratory to be cultured. Is this a good way of testing the sterilizing ability of an autoclave?

A. The American Hospital Association representative described a sound technic of testing sterility which is based on the bacteriologic studies of soil which contains both anaerobic and anaerobic spore-bearing organisms. The technic is described in full detail on page 86 of *Aseptic Treatment of Wounds.*

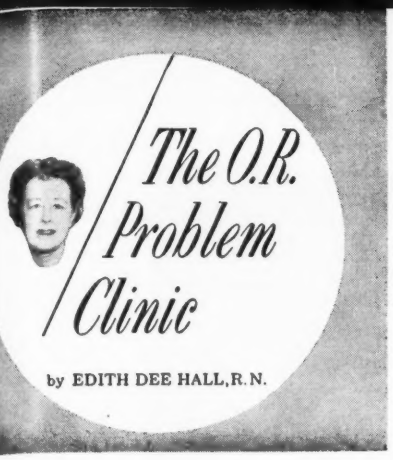
You can also purchase from Baltimore Biologic Laboratories preparations of heat-resistant, spore-forming organisms which are sterilized along with a load. These cultures, when placed in strategic positions in the sterilizer or a pack, will demonstrate that for that given instance, a lethal concentration of steam was or was not present in the sterilizer.

The thing to remember is that testing indicates sterility of the sample tested only. Safe, fool-proof sterilization practices are based on sound knowledge of the tenets of packaging and loading; proper sterilizer operation and maintenance; the use of mechanical controls for impounding a load and measuring the quality of steam present, and the rigid enforcement of these rules by conscientious, qualified personnel.

Q. What is a good soap for a preoperative scrub?

A. Any soap or detergent with at least 2% G-11 content is good, but should not be considered a single-shot germicide. Tincture of green soap is a poor detergent. It will not lather, it has no germicidal action, it is expensive, and it should not be used in the hospital.

This technic as applied to the premature nursery is described in an article in *Surgery, Gynecology and Obstetrics* for November, 1950.



Supervisor Must Take Lead In Good Interpersonal Relationships

• Developing good interpersonal relationships in a department naturally starts with the department head. In the operating room this person, in most instances, is the O. R. supervisor.

A factor which contributes largely toward the development of a desirable relationship between people is early home training. We start off with important assets if we have had the good fortune to be raised in a home in which courtesy and a congenial atmosphere were the rule and not the exception.

Early training in the ability to get along with others is invaluable and far-reaching. The foundations for better relations are made from good intentions and an insight into self and the feelings of others.

Interpersonal relations or relations with the members of her staff should be of vital importance to the O. R. supervisor. It is her responsibility to establish good morale so that each one has the feeling of belonging and a desire to work effectively with others. She is concerned with the development of loyalty, cooperation, and a common purpose, or the basic background for effective working conditions.

The operating room supervisor first finds need for self-examination. Her self-interests color her behavior, and she should, therefore, make a careful study of these factors. To gain respect from others she must have self-respect. This is manifested in her speech, the tone of her voice, her personal appearance, poise, friendliness, and the presence of a quiet inner control.

She should have a sense of fairness, be willing to listen, be approachable and informal to the degree of putting others at ease. Human warmth, governed by a skillful head, is also an asset.

SHOULD JOIN GROUP

The O. R. supervisor needs to enter in and be a member of the group. Her appearance at the coffee break should be usual rather than unusual. To have her walk into a working area should be a matter of course and not one of concern to the worker. This gives her the opportunity to make mental notes, compliment the worker and observe the quality of performance.

Good morale comes from friendliness and appreciation. When criticisms become necessary it works best to compliment, then criticize and compliment again. By this method the worker absorbs the criticism, but is left with a feeling that all is not wrong.

Orders given in the form of a question are received much more readily than authoritative commands. If the operating room supervisor shows understanding and directs others properly, they also develop understanding.

Each member of the staff should be permitted and encouraged to share in making improvements, help in problem-solving, and take an active interest in new developments in the department. For an employee who works in a position of little status, the feeling of belonging and of possessing worth as a worker is most essential.

The supervisor occupies a position of central importance in developing the social status within which her staff works.

There are No Substitutes for Diack Controls

The weakness of culture tests to check autoclaves is that it takes several days of incubation to find Growth. By then, dressings are used and patients may be infected.

Sterilizer controls serve the same purpose without this weakness but only one control—the Diack —is accepted as the easiest to use and the most positive in answering the question.

Some hospitals believe their routine is so perfect that no sterilizer controls are needed. Perhaps so—but we know from 46 years of producing Diack Controls that non-users today become avid users tomorrow. Why?—the answer is evident!

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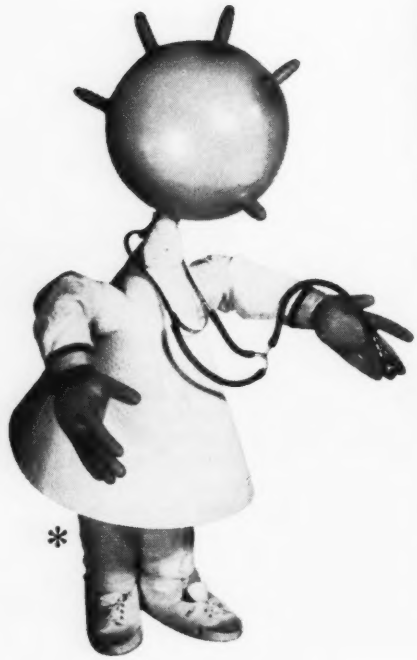

Dr. B. D. WILSON PRESENTS...the care and handling story

In the operating room, today's top-quality surgeons' gloves withstand an amazing amount of hard usage. Yet their life span may be abruptly shortened by a single error or oversight in the course of routine care and sterilization. To help you get maximum service from your surgeons' gloves, the Research Department of the Wilson Rubber Company has prepared an up-to-date manual, THE CARE AND STERILIZATION OF SURGEONS' GLOVES. It is available on request.

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B-D AND WILSON, T.M. REG. U.S. PAT. OFF. 34755 *TRADEMARK THE WILSON RUBBER COMPANY

Announcing 4th Annual Congress

ASSOCIATION OF OPERATING ROOM NURSES

Hotel Statler, Los Angeles, Calif.

February 18-20, 1957

Aerial view of Los Angeles

Planned especially for you...

All operating room nurses are invited, whether or not they are members of the A.O.R.N.

ADVANCE PROGRAM ON FOLLOWING PAGES . . .

Fourth National Congress

ASSOCIATION OF OPERATING ROOM NURSES

Los Angeles, California

February 18-20, 1957

MONDAY, FEBRUARY 18

Morning Sessions

7:30 a.m. — **Registration**

8:30-11:00 — ***Golden State Room, Hotel Statler***

Panel Discussion: Looking into the Future for Operating Room Nurses

Moderator: Dorothy Neiderholzer, R.N., Advisor, Operating Room Nurses Special Conference Group, California State Nurses' Association
Participants:

THE LICENSED VOCATIONAL PROGRAM—Nina B. Crafts, R.N., Director, Nursing Service and Education, Los Angeles County General Hospital

THE STUDENT NURSE VIEWPOINT—Mary Louise Steinke, President, National Student Nurses' Association, Kaiser Foundation Hospital, Oakland, Calif.

THE TWO-YEAR PROGRAM—Dorothea Daniels, R.N., Administrator, Kaiser Foundation Hospital, Los Angeles, and Chairman, Nursing Education Advisory Committee, Los Angeles City College

THE DEGREE PROGRAM—Mrs. Lulu Hassenplug, R.N., Dean, School of Nursing, UCLA Medical Center

THE OPERATING ROOM NURSE'S ROLE IN THE ARMY MEDICAL SERVICE—Col. Inez Haynes, Chief, Army Nurse Corps, Office of the Surgeon General, Washington, D. C.

Discussion, with audience participation

8:30-10:00 — ***Los Angeles Room, Hotel Statler***

Surgery of the Newborn

William Snyder, Jr., M.D., Surgeon, and Digby Leigh, M.D., Anesthesiologist, Children's Hospital, Los Angeles

10:00-11:00 — **The Use of Art in the Operating Room**

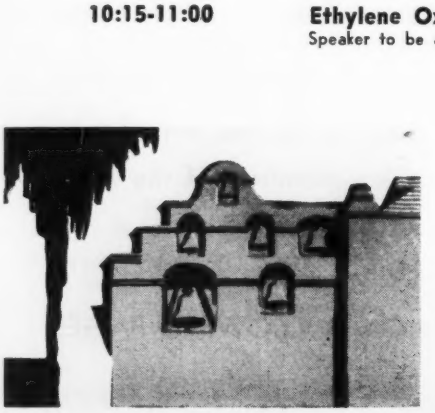
J. Howard Payne, M.D., Assistant Clinical Professor of Surgery, University of Southern California School of Medicine, Los Angeles
Ted Bloodhart and Mrs. Gregg Moris, Medical Artists, Hospital of the Good Samaritan, Los Angeles

8:30-11:00 — ***Wilshire Room, Hotel Statler***

8:30- 9:45 — Subjects and speakers to be announced

9:45-10:15 — **Homologous Serum Hepatitis: Spread, Control and Prevention**
Speaker to be announced

10:15-11:00 — **Ethylene Oxide Gas**
Speaker to be announced



One of many missions in area

Los Angeles City Hall

Afternoon Session

3:00- 5:00 p.m. ***Assembly Room A***

Disaster Day

Program being worked out by Los Angeles civil defense authorities

TUESDAY, FEBRUARY 19

Morning Sessions

8:30-11:00 ***Golden State Room, Hotel Statler***

Panel Discussion: Headaches in the Operating Room

Moderator: Mary Sylvia, R.N., Superintendent of Nurses, Camarillo (Calif.) State Hospital
Participants:

ON CALL AND OVERTIME—Speaker to be announced
SCHEDULES—Pauline Young, R.N., Operating Room Supervisor, Hahnemann Hospital, Philadelphia
APATHY AND ABSENTEEISM—Speaker to be announced
THE PROBLEM SURGEON—Patricia Connor, R.N., Operating Room Supervisor, St. Luke's Hospital, New York City

Discussion, with audience participation

8:30- 9:15 ***Los Angeles Room, Hotel Statler***

Alonzo Neufeld, M.D., Associate Professor of Orthopedic Surgery, College of Medical Evangelists, Los Angeles

9:15-10:00 **Purchasing Directly from the Manufacturer**

Darrell L. Gifford, Manager, Technical Sales Division, American Sterilizer Co., Erie, Pa.

10:00-11:00 **New Adrenal Tumor**

Earle Boehme, M.D., College of Medical Evangelists, Los Angeles

8:30-10:00 ***Wilshire Room, Hotel Statler***

The Post-Anesthesia Unit—Value in Patient Care
(Orientation, visual aids, supportive measures, positioning)
James S. West, M.D., Anesthesiologist, Daniel Freeman Hospital, Los Angeles, and Mrs. Joyce Stromquist, R.N., Daniel Freeman Hospital, Los Angeles

10:00-11:00 **Hypothermia in Surgery**

Robert W. Virtue, M.D., Professor of Anesthesiology, University of Colorado Medical Center, Denver, Colo.

Afternoon Session

3:00- 5:30 p.m. ***Assembly Room A***

Panel Discussion: Sterilization of Supplies

Moderator: John Gabel—Wilmot Castle Co.
Participants:

SATURATED STEAM—J. Hamilton Scott, American Sterilizer Co.
DRY HEAT—Speaker to be announced
STERILIZATION BY GAS—Richard E. Burgess, Director of Control, Don Baxter Co.
ELECTRONIC RADIATION—C. A. Lawrence, Ph.D., Director, Bureau of Laboratories, Los Angeles Department of Health
CHEMICAL DISINFECTION—Emil G. Klarmann, Ph.D., Vice-President, Lehn and Fink Products Corp.

WEDNESDAY, FEBRUARY 20

Morning Sessions

8:30-10:00 — ***Golden State Room, Hotel Statler***

Surgery of the Hand
(Emphasis on preservation and reconstruction, with nurse participation; demonstration of drapes)
J. H. Boyes, M.D., Los Angeles, Past President, American Society for Surgery of the Hand

10:00-11:00 — **The Need for Malpractice Insurance for Operating Room Nurses**
James E. Ludlam, Legal Counsel, California Hospital Association, Los Angeles

8:30-10:00 — ***Los Angeles Room, Hotel Statler***

Cardiac Arrest
W. Mikkelson, M.D., Hospital of the Good Samaritan, Los Angeles
(Visual aids, equipment, medications and trays, with nurse participation)

10:00-11:00 — Speaker and subject to be announced

8:30- 9:30 — ***Wilshire Room, Hotel Statler***

Fires and Explosions in the Operating Room
Speaker to be announced

9:30-11:00 — **Eye Surgery and the Operating Room Nurse**
(Background, functions and opportunities)
Gertrude I. Mason, R.N., Former Chief Surgical Nurse for Ophthalmology Service and Ocular Research Unit, Walter Reed Army Medical Center, Washington, D.C., and Author of "Operating Room Nursing in Surgery of the Eye." Accompanying the lecture will be films on the eye bank and corneal transplant, made by Townley Paton, M.D., Manhattan Eye and Ear Hospital, New York City

Afternoon Sessions

3:00- 5:00 p.m. — ***Assembly Room A***

Problem Clinic
Moderator: J. Norman O'Neill, M.D., President, Los Angeles County Medical Society
Participants
SURGEON—To be announced
HOSPITAL REPRESENTATIVE AND FORMER ADMINISTRATOR—Jack Fulton, Los Angeles
DIRECTOR OF NURSES—Nina B. Craft, R.N., Los Angeles
ANESTHESIOLOGIST—Forrest Leffingwell, M.D., College of Medical Evangelists, Los Angeles
OPERATING ROOM SUPERVISOR—Sister Patricia, Operating Room Supervisor, Charity Hospital, New Orleans, La.
CLINICAL INSTRUCTOR—To be announced

THURSDAY, FEBRUARY 21

The day immediately following Congress sessions has again been designated as "A.O.R.N. Hospital Day." Plans are under way for special programs to be given in Los Angeles hospitals. Details will appear in an early issue of HOSPITAL TOPICS.

LOCAL COMMITTEES FOR CONGRESS

General chairman of all committees: Mrs. Ethel I. West, Methodist Hospital of Southern California. **Co-chairman:** Mrs. Viola Roddewig, Beverly Community Hospital. **President,** A.O.R.N. of Los Angeles: Mrs. Mary Kreitz, Kaiser Foundation Hospital.

Program:
Gloria Castillo, Chairman, Centinela Valley Community Hospital, Inglewood, Calif.
Vivian Warren, White Memorial Hospital
Pierrette Legare, UCLA Medical Center
Bethene Zahm, Hospital of Good Samaritan
Madonna McGlone, Queen of Angels Hospital
Sister Eleanor Francis, Daniel Freeman Hospital
Levis Duke, Surgeon's Office
Mrs. Viola Roddewig, Beverly Community Hospital

Hospitality:
Chairman: Cecelia Lim, Kaiser Foundation Hospital
Lester Lackie, Los Angeles County General Hospital
Mrs. Betty Welcher, Valley Hospital
Emma Pflug, Glendale Sanitarium
Sister Carolita, Queen of Angels
Paula Schulte, Hospital of the Good Samaritan
Mildred Palmer, Harbor General Hospital

Entertainment:
Chairman: Joan Coe, Hollywood Presbyterian
Doris Rogers, Hospital of the Good Samaritan
Trudy Harte, Bella Vista Hospital
Mrs. Mary A. Pierce, West Covina Community Hospital
Helen Jensen, John Wesley Hospital
Betty Montgomery, Surgeon's Office
Loretta Haberman, Los Angeles County General Hospital

Scientific Exhibits:
Chairman: Jerry Peers, UCLA Medical Center
Mrs. Pauline Crance, Burbank Hospital
Valborg Hedback, Surgeon's Nurse
Mary Nalbandian, Centinela Valley Community Hospital
Florence Friedman, City of Hope, Duarte, Calif.

Advance Registration:
Mrs. Laurice Powis, Centinela Valley Community Hospital, Inglewood
Jeanne Najar, Los Angeles County General Hospital
Patricia Warren, Orthopaedic Hospital
Darlene Carlson, North Hollywood Hospital
Mrs. Florence Hayes, Los Angeles County General Hospital
Evelyn Attwood, Cedars of Lebanon Hospital
Gloria Scott, North Hollywood Hospital

Publicity: Bethene Zahm
Mrs. Darlene Carlson
Florence Friedman
Trudy Harte
Betty Welcher

PLEASE REGISTER IN ADVANCE

Advance registration will save time. Your badge and program can then be picked up at a special desk upon your arrival.

You may register by sending a check or money order for the $3.00 registration fee, payable to the Association of Operating Room Nurses, to:

Miss Laurice Powis, R.N.
5144 W. 122nd St.
Hawthorne, Calif.

Please include your name, hospital address, and state registration number.

It is not necessary that you be a member of the A.O.R.N., but you must be a registered professional nurse. If you do not register in advance, please bring your registration card with you.

ARRANGEMENTS FOR SISTERS

As an accommodation particularly to the Catholic Sisters, arrangements have been made for Mass to be said daily in the hotel.

A retiring room will also be set aside for Sisters.

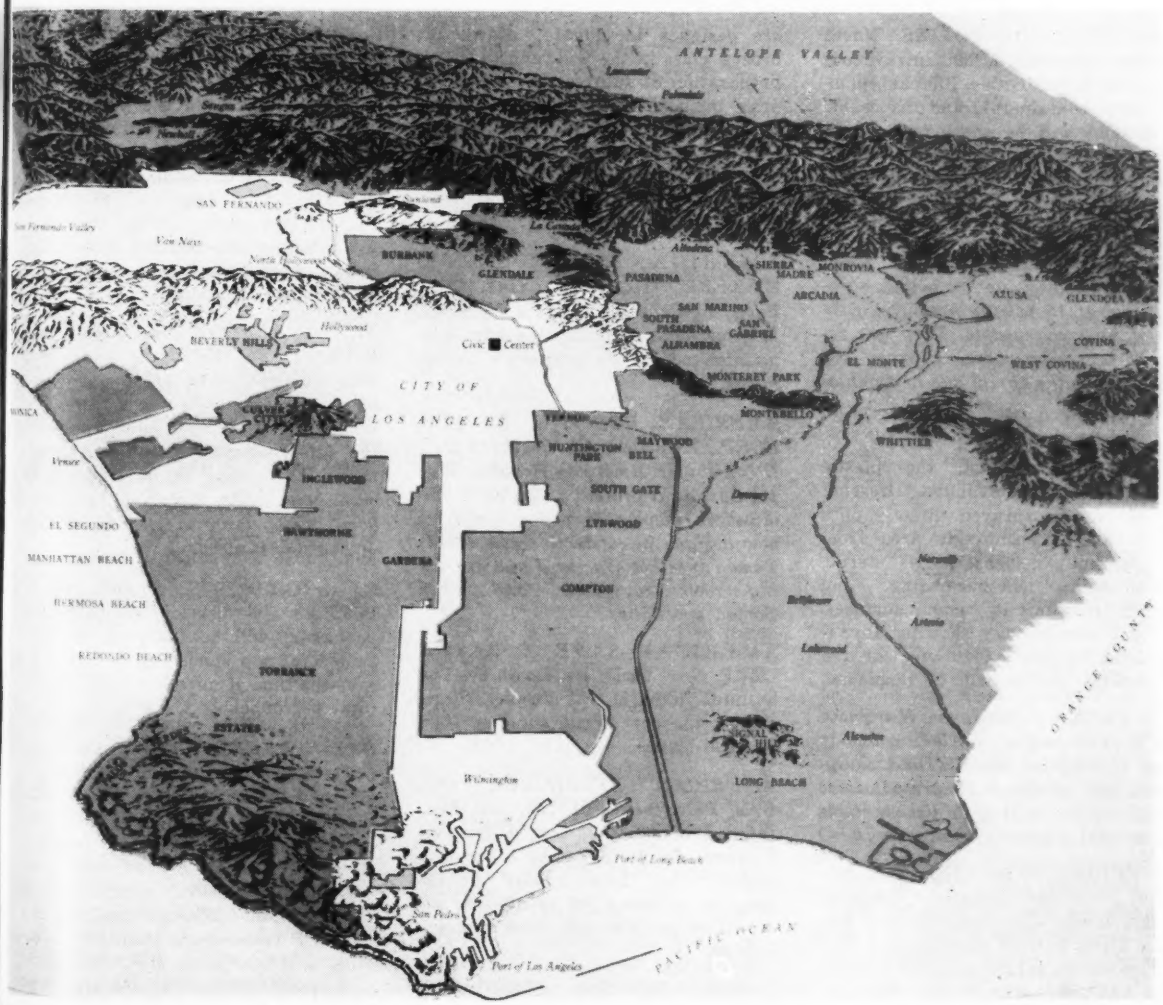
SCIENTIFIC EXHIBITS

Members of the local committee are planning the scientific exhibits for the Congress. Details will be announced in the December issue of HOSPITAL TOPICS.

POST-CONVENTION TOURS

For congress registrants who may wish to take a vacation following the meeting, information on tours to surrounding areas will be published in an early issue.

Map of Los Angeles area. Not shown are Ventura County (at left of San Fernando Valley) and San Bernardino County (off to right).



On-the-Spot Answers

to Maintenance and Operation Problems

...from these technical exhibitors

These carefully selected technical exhibitors will be on hand to give you the answers to your maintenance and operation problems, and to show you how you can utilize their operating room supplies and equipment more effectively. They fully realize the advantage of keeping operating room equipment and attachments functioning smoothly. Well-qualified representatives will be glad to demonstrate fully any product, apparatus, or attachment. Here, too, is the place to see everything that's in your field.

ABBOTT LABORATORIES, North Chicago. Booth 69. Abbott intravenous solutions, blood bottles, Pliapak (plastic blood containers), and disposable equipment will be shown; also pentothal sodium,® Quelicin, and related products used in the operating room.

A.C.D. HOSPITAL SPECIALTIES, Pasadena, Calif. Booth 18. Featured will be S.E.S.I. and Atlas nylon syringes—unbreakable, boilable, autoclavable at 15 pounds pressure, leakproof, interchangeable. They are insured for three years. Plunger will not stick in the barrel due to coagulation of blood.

AEROPLAST CORP., Dayton, O. Booth 87. Aeroplast, the plastic dressing, will be exhibited. Dressing which can be sprayed directly onto lesion and adjacent skin area from aerosol-type dispenser, is sterile, transparent, non-macerating, and nonadherent to raw wound surfaces. Color transparencies showing advantages of application to surgical and traumatic wounds will be displayed.

A.S. ALOE CO., St. Louis, Mo. Booth 65. A cross-section of Aloe's complete line of hospital supplies and equipment will be shown. Representatives invite nurses to stop to discuss items of mutual interest.

AMERICAN CYANAMID CO., Surgical Products Division. Danbury, Conn. Booth 112. Company will feature Davis & Geck Surgilar and Surgilope sterile suture pack for surgical gut and silk, respectively. Packages are designed to elimate hazards of broken glass in the O.R. and to speed preparation of sutures. Other D & G firsts include Measuroll silk and cotton, Surgaloy stainless steel sature U.S.P., spiral-wound surgical gut, silk and cotton, and Aureomycin Chlortetracycline Hydrochloride products.

AMERICAN CYSTOSCOPE MAKERS, INC., New York City. Booth 50. Representatives will provide informational assistance on care and maintenance of the company's instruments.

AMERICAN HOSPITAL SUPPLY CORP., Evanston, Ill. Booths A,B,C, D (on stage). American Hospital Supply Corp. will present a display of the latest in disposable paper products, new designs in conductive sole shoes, Tomac anesthetist's stand and operating room equipment, and other Tomac specialties.

AMERICAN SAFETY RAZOR CORP. New York City. Booth 89. The hospital division will display Sterisharps, the new sterile stainless steel surgical blades.

AMERICAN STERILIZER CO., Erie, Pa. Booths 104, 105, 106. Featured will be the new Ultrasonic Cleaner. An entirely new concept in cleaning has been applied to the toughest cleaning job of all—the removal of protein soil—with amazing results.

ASEPTIC-THERMO INDICATOR Co., North Hollywood, Calif. Booth 58. Autoclave sterilization aids; "Steam-Clix," the four way color-changing indicator; the new, most readable indicator, "Sterilometers"; the A.T.I. Steri-Line syringes, needle, and catheter-sterilizing bags, both single and duet types, with the built-in indicator. Introducing the new A.T.I. needle and catheter holders for easier, safer handling of needle and catheter sterilization.

AUSTENAL, INC., New York City. Booth 94. The Vitallium booth will have an assortment of standard internal fixation appliances showing the versatility of the line, particularly in the intertrochanteric and hip prosthesis field. Also to be shown are many new items, including Vitallium bone drills, designed specifically for orthopedic surgery.

C. R. BARD, INC., Summit, N. J. Booth 85. New development in sterile packaging will be featured, as well as several new items—all designed to save the time of nurses and other hospital personnel.

BARD-PARKER CO., INC., Danbury, Conn. Booth 60. Surgical Knife handles and Rib-Back blades will be displayed, along with Rack-Pack for extra blade protection; blade forceps; Reese Dermatone; B-P formaldehyde germicide—sporicidal, virucidal, and tuberculocidal—Chlorophenyl, and the new B-P concentrate Halimide. Company will also show B-P blade jars, instrument containers, transfer for-

ceps, and C. F. pipettes with permanent markings.

BAUER & BLACK, Chicago, Ill. Booths 79, 80. Bauer & Black will display the new CURITY Sutures, more finely gauged, yet with greater tensile strength in a packet which will work—formaldehyde or no; prepackaged postoperative dressings, ready to be applied; and the new CURITY adhesive, which unwinds easily, stays on better, and comes off clean.

DON BAXTER, INC., Glendale, Calif. Booth 40. A complete line of intravenous solutions and blood transfusion equipment will be shown, along with a complete line of plastic catheters and intubation tubes.

RUDOLPH BEAVER CO., Waltham, Mass. Booth 96. Featured: the new Beaver blade file system with tray pack blades for use in hospital O. R.'s. Blade file can be used with either dry heat or cold solution. Company manufactures 28 replaceable blade shapes, including those for general, neuro, thoracic, bone and joint, eye, plastic, and other types of fine surgery.

BECTON, DICKINSON AND CO., Rutherford, N. J. Booth 67. Exhibited will be the new Multifit control syringe. All glass and metal parts are interchangeable thus eliminating costly repairs or complete replacement. Also on display will be Wilson surgeons' gloves, Multifit syringes, Yale needles, and Ace elastic bandages.

BIRTCHER CORP., Los Angeles, Calif. Booth 46. Equipment for cardiac resuscitation will be displayed; also three major electro-surgical units, along with a sample of every electrosurgical electrode that company manufactures. A shortwave diathermy unit will be set up in the booth to demonstrate a technic for rapidly increasing a patient's temperature after an operation utilizing hypothermy.

S. BLICKMAN, INC., Weehawken, N. J. Booth 44. Explosion-proof stainless steel operating room equipment will be displayed, including such items as instrument stands, surgeon's and anesthetist's stools, instrument tables, kick buckets, and anesthetist's tables. All are fitted with conductive casters, tips or glides, and feature seamless welded construction.

JOHN BUNN CORP., Buffalo, N. Y., Booth 115A. All necessary equipment for complete glove-processing room will be displayed. Featured will be the Bunn Glove tester, with its own compressor, to enable operator to rapidly and accurately locate pinholes and weak spots in surgical gloves.

WILMOT CASTLE CO., Rochester, N. Y. Booths 39, 39A. Modern Operating lights with camera for color photography without additional lighting will be exhibited, along with the new, compact, self-contained gas sterilizer for delicate instruments such as cystoscopes, catheters, endoscopes, and bronchoscopes. This sterilizer processes all types of plastics, including polyethylene and polyvinyl wrappers, and all rubber goods.

CHESEBROUGH - POND'S, INC., New York City. Booth 81. Featuring prepacked sterile Vaseline petrolatum gauze, which conforms to the requirements of the *U.S.P. XV*, and is now standard in hospitals. It is available in five sizes; can be used effectively in O.R., emergency, nursing, E.N.T., plastic unit, and wards.

GILBERT HYDE CHICK CO., Oakland, Calif. Booth 72. The DV orthopedic and operating table, Davis patient roller, Chick combination leg cradle and foot rest, Dr. Virgin fracture table, and new Chick Variety infant's cast table will be exhibited.

CLAY-ADAMS, INC., New York City. Booth 64. Three new products of interest to operating room nurses will be displayed—the Ayres stomach and colon brushes for cancer diagnosis; Siliclad, a water-soluble silicone concentrate; Huber Lung Model, a new dissectable teaching aid. Clay-Adams regular assortment of operating room specialties, including Sterile Intramedic polyethylene tubing, Autoclip applier, and CRI germicide, will also be displayed.

COCA-COLA CO., Atlanta, Ga. Booth 45. Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Co. of Los Angeles, and the Coca-Cola Co.

CONNECTICUT BANDAGE MILLS, INC., Bridgeport, Conn. Booth 97. Representatives will be on hand to discuss the latest methods of using Elasticfoam foam rubber pressure bandage and the Foamtrac traction bandage. New research products on display will include Alumafoam fence splits and nasal splints. Demonstrations will be made of the Plastafoam cast padding, Alumafoam finger splints, and the complete line of coNco cotton elastic and rubber-reinforced bandages.

CUTTER LABORATORIES, Berkeley, Calif. Booths 2, 3. Cutter's answer to the increased interest in plastic containers for blood is the Cutter Saftiflex and allied equipment, which will be demonstrated at the meeting.

DAVOL RUBBER CO., Providence, R. I. Booth 57. On exhibit will be a new, improved line of disposable plastic catheters and surgical tubes, conductive rubber accessories for operating room safety, special surgical adjuvants, and hospital rubber goods.

GEORGE DEMAIN & CO., Los Angeles, Calif. Booth 10. On exhibit will be the Moro patented bedside bag and patented vinyl plastic permanent holder. The permanent vinyl plastic holders have a full adhesive pressure-sensitive backing that will adhere and re-adhere to any surface, such as linens, metal, wood, etc., and will take autoclaving. Moro Bags are wax-permeated throughout, have stay-open design, with a metal strip across the top to fit into the holders. Can be used in surgery, OB, recovery rooms, post-operative dressing tables, laboratories, contamination wards, etc.

J. A. DEKNATEL & SON, INC., Queen's Village, Long Island, N. Y. Booth 75. A complete line of surgical sutures will be shown, featuring the Deknatel dry sterile Readi-Wound ligature reels. The longer length makes the Deknatel reel the correct size to fit comfortably in the hand. The suture size is clearly marked on the reel. Deknatel Name-on Beads will also be shown.

DEPUY MFG CO. INC., Warsaw, Ind. Booth 92. Featured among many new products for orthopedic surgery will be the DePuy universal intertrochanteric bone plate, which can be used in conjunction with Smith-Petersen nails or Lorenzo screws. No bending is required to correct for vertical or lateral angulation.

DITTMAR AND PENN CORP., Philadelphia, Pa. Booth 110. Display will feature a complete line of fine surgical instruments. Many new instruments will be available for inspection. Trained personnel will be on hand to explain these instruments and help the operating room supervisor to become better acquainted with them.

DOHO CHEMICAL CORP., New York City. Booth 16. Mallon Chemical Corp., a subsidiary of Doho Chemical Corp., makers of Auralgan, New Otosmosan, and Rhinalgan, will exhibit Rectalgan, the liquid topical anesthesia for relief of pain and itching in hemorrhoids and pruritus; and in pre and postoperative cases; Dermo-

(Continued on next page)

plast, the aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions.

DUKE LABORATORIES, South Norwalk, Conn. Booth 28. Elastoplast bandages and unit dressing will be displayed.

E & J MFG. CO., Burbank, Calif. Booth 52. Anesthesia apparatus, resuscitators, and the battery-operated, explosion-proof cardiac monitor for visual or aural monitoring of electrical output of heart will be shown.

ETHICON, INC., Somerville, N. J. Booths 62, 63. Ethicon will exhibit CP Surgical Gut, Tru-Permanized Silk and other textile sutures; Atraloc eyeless needle sutures; Bio-Sorb absorbable dusting powder; Gamphen antiseptic surgical soap; Tantalum gauze and other Tantalum surgical materials; SUTUPAK—pre-cut sterile materials; surgical steel sutures and gauze, Surgiset and Pocket Surgiset—sutures assortments; LIGAPAK—spiral wound sutures; new ophthalmic sutures.

FENGEL CORP., New York City. Booth 37. The company will display a full line of surgical and laboratory supplies including rubber goods, glassware, surgical instruments, hypodermic needles, and syringes. Featured will be Swedish stainless steel instruments, and English non-corrosive surgical needles.

FENWAL LABORATORIES, INC., Framingham, Mass. Booth 107. Exhibit will feature complete line of plastic blood equipment to provide safe technic for collection, processing, storage, transportation, and infusion of whole citrated human blood. Display includes Fenwal's plastic Blood-Pack, administration sets, and ancillary equipment. Demonstrations will be given in use of Hemolator, plasma extractor, pressure infusor, triple pack, and other products designed to provide better blood at indicated moment, at predictable rate, for predetermined quantity.

GOMCO SURGICAL MFG. CORP., Buffalo, New York. Booth 49. Comco will show explosion-proof hospital suction and suction-ether units, thermotic drainage pumps, thermotic thoracic pumps, tidal irrigator and cystometer, hospital aspirators.

B. F. GOODRICH INDUSTRIAL PRODUCTS CO., Akron, O. Booth 91. The company, a division of the B. F. Goodrich Co., will exhibit surgeons' gloves, Koroseal hospital sheeting, film, mattress and pillow covers, rubber and Koroseal tubing, catheters and other surgical tubes, ice packs, invalid cushions, hot-water bottles, and other rubber sundries for hospitals.

GUDEBROD BROTHERS SILK CO., INC., New York City. Booth 35. Silk sutures with the cerethermic finish in Dri-Pak will be featured, along with the complete line of Gudebrod's non-absorbable sutures and Gudebrod developments to make operating room procedures easier.

HAROLD SUPPLY CORP., New York City. Booth 51. The Steriphane system for sterilizing needles and syringes, featuring the use of the Steriphane stainless steel needle dispenser, will be shown. The dispenser delivers individually wrapped sterile needles as needed at the nursing area. The integrated system starts with processing in central supply and is terminated at the site of injection. The new Sterilope for operating room catheter technic will also be shown.

HAUSTED MFG. CO. Medina, O. Booth 53. Complete units for emergency room and recovery room. Large selection of accessories. Sliding and tilting Easy lift—standard. Convertable, an emergency OB table, portable examining table, and stretcher, New—only intermittent traction machine that compensates for the movement of the patient.

Hydraulically operated, electronically controlled. New invalid chair, enabling transfer of patient in horizontal position, with back raised and legs lowered by a turn of a crank while the seat is lowered.

HOMER HIGGS & ASSOCIATES, INC., New York City. Booth 77. The Faultless Rubber Co. line of surgical gloves will be on display.

HOFFMANN-LA ROCHE, INC., Roche Park, N. J. Booth 74. Four products of interest to operating room nurses will be featured: the synthetic narcotic, LEVO-DROMORAN, for relief of severe pain; NISENTIL, a rapid-acting, synthetic narcotic analgesic; ARFONAD, a rapid, short-acting vaso-depressor; and LORFAN, a potent drug for preventing or relieving narcotic-induced respiratory depression.

FRANKLIN C. HOLLISTER CO., Chicago, Ill. Booth 88. The company will exhibit Ident-A-Band, the effective on-the-wrist system of patient identification, with the patient's name, hospital number, and doctor's name sealed inside the Ident-A-Band. Averts errors in identification in surgery and recovery room.

JOHNSON & JOHNSON, New Brunswick, N. J. Booths 82, 83. Stop to learn who won the annual A.O.R.N. convention contest. Company will exhibit new sizes in both wet and dry types of nonadhering dressings, the unit-wrapped Ray-Tec sponges counted and tied in 10's and other new products.

THE LAWTON CO., New York City. Booth 21. Surgical instruments, particularly in the field of thoracic and cardiac surgery, will be exhibited.

LEHN & FINK PRODUCTS CORP., New York City. Booth 70. Technical representatives will be pleased to discuss disinfecting problems with operating room nurses. Featured will be: Amphyl brand disinfectant, Lysol, O-Syl, and Lehn & Fink instrument germicide.

THE LIN COMPANY, Clinton, Okla. Booth 26. On exhibit will be the only explosion-proof automatic surgical Sterile Solution Warmer of its kind, designed to save time and efforts in operating rooms and wards alike. Adjustable thermostat control keeps solution at fixed temperature indefinitely, needs no attention from busy circulating nurse. Approved by Underwriters Laboratories for explosive atmosphere.

MACBICK CO., Cambridge, Mass. Booth 114. Pour-O-Vac procedure for sealing and handling surgical fluids will be featured. This safe, economical technic features improved design and new self-sealing closure.

MACGREGOR INSTRUMENT CO., Needham, Mass. Booth 115B. A complete line of quality VIM hypodermic needles, syringes, and other surgical specialties will be displayed. Featured will be the VIM Gabriel vial aspirating syringe, VIM clear barrel interchangeable syringes, and the new sterile packaged Damascus hypodermic needle.

S. E. MASSENGILL CO., Bristol, Tenn. Booth 78. Company will feature Adrenosem salicylate, a new systemic hemostat. Color photographs will be exhibited to demonstrate effectiveness of product in maintaining tone of capillary wall, thus reducing permeability.

MATTHAY HOSPITAL SUPPLY CO., Los Angeles, Calif. Booth 90. Company will feature new line of satin, stainless steel surgical instruments; the Matthay firm-grip needle holder in satin and polished finishes, with a special tungsten, chromium, cobalt and tantalum carbide alloy jaw; an improved finger-touch control stainless steel Mayo stand, and other items.

MEAD JOHNSON & Co., Evansville, Ind. Booth 71. Many new features of the constantly closed system for blood transfusion and parenteral solution infusion will be displayed, including the inverted filter for unimpeded flow, the filter-then-pressure system for safety in rapid blood transfusions, and the dual drip Y-set for separate control of blood and solution flow.

MEINECKE & CO., New York City. Booth 68. Displayed will be two products of interest to O. R. supervisors—offering superior technic, convenience, and economy—Haemo-Sol for cleaning surgical instruments and equipment, and Sterilwraps for wrapping sterile supplies.

V. MUELLER & CO., Chicago, Ill. Booth 98. Morch surgical respirator, R-65 tungsten edge surgical scissors, and an instrument rack will be featured, along with Mueller's explosion-proof pumps and a new 1060-page "Guide to Purchasing."

OHIO CHEMICAL & SURGICAL EQUIPMENT CO., Madison, Wis. Booths 47, 48. Ohio Chemical proudly introduces its improved method of packaging sutures, which includes plastic envelopes; Dispenso-reels for unwinding sutures without kinking or tangling; a greater quantity of sutures in smaller Steriljar, and new ligature dispensing cases. Also on display will be Stille stainless steel surgical instruments.

ORTHOPEDIC EQUIPMENT CO., Bourbon, Ind. Booth 76. Exhibit will consist of splints, fracture equipment, and SMo internal bone appliances.

ORTHOPEDIC FRAME CO., Kalamazoo, Mich. Booth 111. The Orthopedic Frame Co. will show its Stryker plaster dispenser which keeps plaster mess in the operating room to an absolute minimum. The Stryker electro-surgical unit, which combines several power surgical tools, and a new prone position pad will also be exhibited.

PARKE, DAVIS & CO., Detroit, Mich. Booth 86. Hospital representatives will be on hand to discuss important hospital products. New specialties such as Chloromycetin intramuscular and Surital sodium, and the 5-gram Steri-Vial, will be featured, along with Benadryl, penicillin S-R and S-R-D, Thrombin Topical, Oxycel and surgical dressings.

PELTON & CRANE CO., Charlotte, N. C. Booth 100. High-speed Pelton autoclaves, like the large hospital autoclaves, generate and store steam that is available for use at all times. For emergency use, forgotten or dropped instruments are sterilized in three minutes at 27 lbs. pressure. Autoclaves are portable, self-contained—can be plugged in anywhere. Ideal in all emergency rooms or outside of operating rooms. All three sizes will be demonstrated.

GEORGE P. PILLING & SON CO., Philadelphia, Pa. Booth 36. The Pilling exhibit will have on display a comprehensive selection of its important items. Representatives will be glad to answer questions on the care of Pilling instruments and equipment.

PRATT HOSPITAL EQUIPMENT CO., Los Angeles, Calif. Booth 66. New system of cysto water supply and storage, adaptable to both old and new cysto room, will be demonstrated. Also shown will be suction equipment for the entire hospital—surgery, recovery rooms, and wards.

RANDALL FAICHNEY CORP., Boston, Mass. Booth 95. Ranfac line of quality precision hypodermic instruments will be featured., Many new Ranfac operating room and central supply specialty items will be introduced, including the safety lock adapters for plastic tubing. Also shown will be disposable intravenous and transfusion outfits and stainless steel cases for autoclaving spinal anesthesia, lumbar puncture, and venous pressure sets.

RICHARDS MFG. CO., Memphis, Tenn. Booth 1. Company invites operating room nurses to visit the booth, meet its factory-trained representative, and look over a display of the latest in orthopedic instruments and SMO surgical implants.

RITTER CO. INC., Rochester, Booth 59. Equipment of practical assistance to surgeons and the O.R. nursing staff will be on display for examination and discussion. Up-to-date tables for genitourinary procedures and the latest chair-table for ophthalmology, ENT, and the plastic surgeon will be featured.

DENNIS R. SCANLAN, JR., INC., New York City and St. Paul, Minn. Booth 42. The complete line of Scanlan Swedish stainless steel surgical instruments, known the world over for their quality, balance, and design, will be displayed.

CHARLES A. SCHMIDT INSTRUMENT CO., St. Louis, Mo. Booth 6. Complete line of orthopedic instruments will be exhibited, including the Lottes tibia and femur nails, Key hip nail, and Key periosteal elevator. Also displayed will be the Lahay Adjustable Leg Rest and Adjusta-Table, and the Hohm neuro-surgical table.

SCHOLL MFG. CO., INC. Chicago, Ill. Booth 55. New methods of applying Tubegauz seamless tubular gauze dressing will be featured. Demonstrations will be performed by registered nurses. Also the complete double-seal line of hospital adhesives will be shown.

SEAMLESS RUBBER CO., New Haven, Conn. Booth 17. Lacta breast pads, soft and anatomically correct, will be featured, along with seamless "Kolor-sized" and "Kolor-marked" surgeons' gloves, Pro-Cap adhesive plaster, string-tied bandages, and prepackaged surgical dressings.

SHAMPAINE CO., St. Louis, Mo. Booth 99. Shampaine major operating table S-1502 will be displayed. With this completely head-end controlled table, anesthetist can remain seated during all surgical activity, and does not have to reach into the sterile, draped area, or to lose contact with patient at any time. All controls are within easy, instant reach. Table assumes all conventional and extreme operative positions, without vibration or whip at any height.

J. SKLAR MFG. CO., Long Island City, N. Y. Booth 45. Company will display recently developed instruments in thoracic and cardiovascular fields. Also shown will be fireproof and explosion proof suction and ether equipment and the new portable Junior Tompkins aspirator.

SMITH & UNDERWOOD, Royal Oak, Mich. Booth 41. New Inform controls will be exhibited along with standard Diack sterilizer controls. Inform controls are for use in the terminal sterilization of infant formula at 230°F. Souvenir manicure sticks free at booth.

SNOWDEN-PENCER CORP., Los Gatos, Calif. Booth 38. Alton Ochsner, M.D., New Orleans surgeon, assisted the company in perfecting a line of surgical scissors with tungsten-

(Continued on next page)

carbide cutting edges. Material is permanently built into the cutting blade of the scissors. It offers extraordinary resistance to wear and maintains sharpness for extremely long periods of time.

E. R. SQUIBB & SONS, New York City. Booths 101, 102. Company will present latest information on development of new therapeutic agents for prevention and treatment of disease. Results of research are available to the medical profession in new products, or improvements in products already marketed.

STORZ INSTRUMENT CO., St. Louis, Mo. Booth 87A. Company will display instruments for eye, ear, nose, throat, thoracic, and neuro-surgery. Representatives will be happy to answer any questions concerning the care and maintenance of surgical instruments, as well as provide information on means of identifying high-quality instruments.

TRAVENOL LABORATORIES, Inc., Morton Grove, Ill. Booth 73. Travenol will demonstrate INCERT, the new device for supplementing parenteral solutions. With INCERT vitamins and electrolytes can be added without use of syringe and needles, and sterility of parenteral solutions maintained.

UPJOHN CO., Kalamazoo, Mich. Booth 95. Members of the medical profession are invited to visit the Upjohn booth where members of the company's professional detail staff will be happy to discuss subjects of mutual interest.

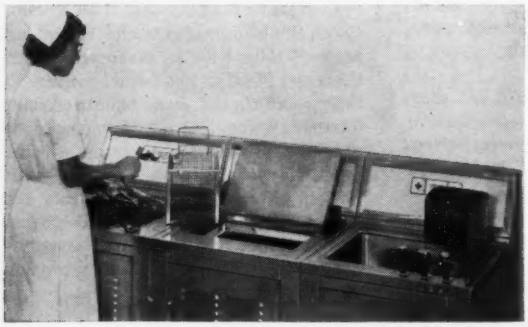
VESTAL INC., St. Louis, Mo. Booth 25. The new Septisol antiseptic soap, providing increased skin protection with greater mildness, will be featured at the booth.

EDWARD WECK & CO., Brooklyn, N. Y. Booth 43. Company will display: Weck-made slenderized surgical instruments, lighter, more precise, more delicate, less traumatic; Weck Bull dog-Jaw needle holders; Weck electron-sterilized applicators and tongue blades; Weck autoclave change ink and pencils; Weck glare-proof finish surgical instruments.

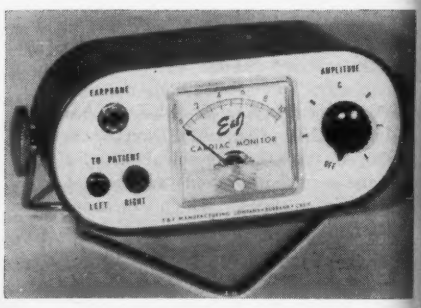
WINTHROP LABORATORIES, New York City. Booth 84. On display will be ALEVAIRE, nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and other pulmonary disorders, and PHISOHEX, hypoallergenic, soap-free sudsing detergent with antibacterial properties on routine use.

ZIMMER MFG. CO., Warsaw, Ind. Booth 103. The new Badgley hip nail with instruments, the new adjustable drill guide and angle finder for use with Jewett nails, the Ritchie nail starter for use with Smith-Petersen nails, will be shown. Also featured: the new hip nail and many other new items in orthopedic surgery.

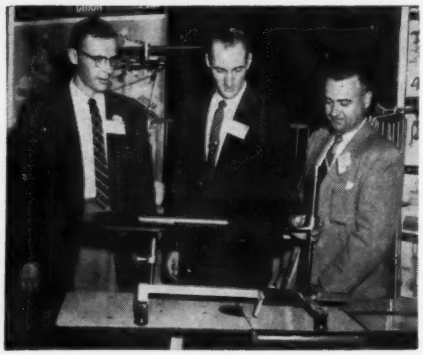
Brand New Products to be Shown at A. O. R. N.



A few of the latest items which will be displayed by A.O.R.N. exhibitors are shown here. Above is American Sterilizer's ultrasonic cleaner, which utilizes high-frequency sound waves to clean instruments in 60 seconds.



Above: E & J Mfg. Co's cardiac monitor is a battery-operated, explosion-proof meter for visual or aural monitoring of electrical output of heart.



Right: Wilmot Castle's new automatic gas sterilizer will also be shown at the A.O.R.N. Pictured here are (l. to r.): M. G. McBane, Wilmot Castle; A. J. Wiese, USPHS Hospital, Chicago, and Thomas C. Thompson, ECA/U.S. Operations Mission, Rio de Janeiro, Brazil.

Right: First complete infant's operating table, now going into production, was introduced to the hospital field by Gilbert Hyde Chick Co. at the American Hospital Association convention in Chicago, September 17-20. Shown here with the operating table are (l. to r.): John R. Shepard, manager of business office, University of Iowa Hospitals, Iowa City; George Rosselle, Gilbert Hyde Chick Co., and Charles C. Ingersoll, assistant superintendent, University of Iowa Hospitals.

Announcing

Gudebrod's new CERETHERMIC* FINISH SILK

the most important advance in silk sutures in 20 years

- a new, higher standard in maintaining and preserving suture strength.
- unequalled in handling qualities, cut ends won't fray.
- smoothness never before attained, virtually no adherence to tissue.

in COLOR-CODED silk sutures

TRADE MARK PATENT APPLIED FOR

Available in CHAMPION serum-proof silk, pre-sterilized DRI-PAK*, cut lengths ready for use

Gudebrod Bros. Silk Co., Inc.
225 West 34th St., New York 1, N.Y.

To secure ample testing samples, please complete and mail this card (no postage required).

GUDEBROD BROS. SILK CO., INC., 225 W. 34th St., New York 1, N.Y.

Gentlemen: Send sample DRI-PAK jar of Gudebrod Color-Coded Silk Sutures with CERETHERMIC FINISH to the Operating Room Supervisor.

_____ R.N.

HOSPITAL _____

CITY _____ STATE _____

SIGNATURE _____

Gudebrod

SILK SUTURES, with the CERETHERMIC* FINISH,

speed
operating time

The truly superior handling qualities of these new sutures make operating procedures easier for both the surgeon and the O.R. Supervisor.
You can get this sample jar by sending the postpaid return card.

Send for this generous sample package

Use Gudebrod **COLOR CODED** sutures for positive identification

TRADE MARK PATENT APPLIED FOR

*T.M.

FIRST CLASS
Permit No. 1598
Sec. 34.9 P.L.&R.
New York, N.Y.

BUSINESS REPLY CARD
No postage stamp necessary if mailed in the United States

POSTAGE WILL BE PAID BY

Surgical Division

GUDEBROD BROS. SILK CO., INC.
225 W. 34th STREET
NEW YORK 1, NEW YORK

Mail this card for sample package which contains one dozen assorted sizes of Color-Coded Silk Sutures in DRI-PAK Jar, sizes 2-0, 3-0, 4-0.

AHA Appoints Brown Administrative Director

Madison B. Brown, M.D., has been appointed to the newly created position of director of administrative services, American Hospital Association. He will coordinate Association activities in hospital organization and business practices, Blue Cross and hospital reimbursement, hospital planning and plant operation, and other related areas.

Dr. Brown was formerly executive vice-president and medical director, Hahnemann Medical College and Hospital, Philadelphia.

Officers Elected by Catholic Nurses

The National Council of Catholic Nurses, meeting in Milwaukee, Wis., in September, elected Mary Knapp, Akron, O., president.

First vice-president is Mrs. Marie Costello, Chicago. Mrs. Mary Delehanty, Brooklyn, N.Y., was elected second vice-president.

Dedicate U. of Miss. Medical Center

The University of Mississippi Medical Center, Jackson, was dedicated in a two-day program October 23 and 24, at which many leading medical educators spoke.

The program also marked the first senior class of the University of Mississippi School of Medieine.

Formerly a two-year institution, the school moved last fall from the Oxford campus to the new center at Jackson. A three-wing, eight-story building houses a 355-bed university hospital, the school, departments of medical technology and nursing, a library, and research laboratories.

Plan Rehabilitation Center For Chronically Ill

One of three additions to Hadley Memorial Hospital, Hays, Kan., will be a wing for treatment of the chronically ill and their rehabilitation, Austin Evans, administrator, has announced.

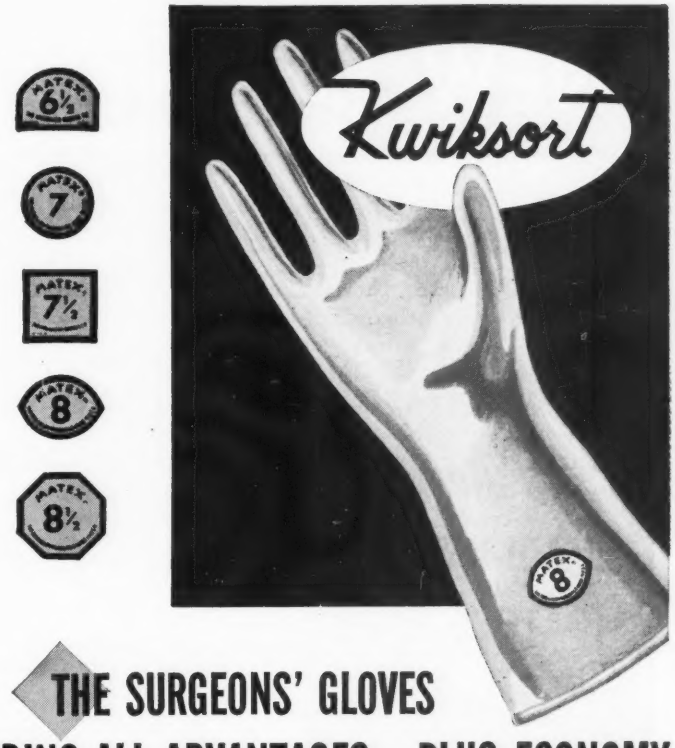
The four-story chronic disease wing will, when completed, be the only treatment center of its type between Kansas City and Denver, and between Omaha and Oklahoma City.

Designed for persons of all ages, the Hadley unit will treat the disabled, the chronically ill, and psychiatric patients.

Welfare and Health Council Adopts New Name

The Community Council of Greater New York, Inc., is now the official name for the former Welfare and Health Council of New York City, Carl M. Loeb, Jr., president, has announced.

The newly organized council, central coordinating and planning body for public and private welfare and health services in the New York City area, is still located at 44 E. 23rd St.



THE SURGEONS' GLOVES
OFFERING ALL ADVANTAGES—PLUS ECONOMY

MATEX (white) and **MASSILLON** Latex (brown) surgeons' gloves are economical to use—regardless of original cost. This is true because:

- MATEX and MASSILLON Latex gloves are made from pure, virgin latex. Thus they resist the adverse effects of repeated autoclaving—and last longer.
- Exclusive KWIKSORT permanent and indestructible size markings speed sorting and pairing—reduce labor costs.
- And they are anatomically designed for perfect fit—to provide comfort and bare-fingered tactility.

For greater economy and satisfaction — get MATEX and MASSILLON Latex surgical gloves from your hospital supply source.

THE
MASSILLON RUBBER COMPANY
MASSILLON, OHIO

prescription pad

Sulfonamide for Urinary Infection

Thiosulfil is a new sulfonamide manufactured by Ayerst Laboratories for treatment of urinary tract infections.

Alkalinization is not required, and fluids may be restricted rather than forced, the manufacturer says. Other advantages listed are greater solubility, lower acetylation in urine, potent bacteriostatic activity, prompt, almost complete absorption, and rapid excretion.

Thiosulfil can be used concurrently with any of the antibiotics.

Tablets (0.25 gm. per tablet) are supplied in bottles of 100 and 1,000; the suspension comes in 4 and 16-oz. bottles (0.25 gm. per 5 cc.).

Treatment of Vaginitis

Sterisil Vaginal Gel, manufactured by Warner-Chilcott Laboratories, is for the treatment of vaginitis and cervicitis.

It is a broad-spectrum chemotherapeutic agent composed of hexetidine 0.1% incorporated in a colorless, nonstaining vaginal gel. It is said to be effective against mixed bacterial trichomonal and monilial infections.

Sterisil is packaged in a 1½-oz. tube with six disposable applicators.

Penicillin V Suspension

Compocillin® V., Abbott's new ready-mixed penicillin V oral suspension, provides concentrations as high as parenteral penicillin G and blood levels three times higher than penicillin G, according to the manufacturer.

It is recommended for all infections produced by penicillin-sensitive organisms, and as a prophylaxis in rheumatic fever and rheumatic heart disease. Adverse reactions are said to be rare.

Each 5-cc. teaspoonful of the banana-flavored preparation provides 300,000 units. The product is supplied in 80-cc. bottles.

For Metabolic Insufficency

Cytomel (L-triidothyronine), for the treatment of metabolic insufficiency, has been introduced by Smith, Kline and French Laboratories.

Recommended starting dose is 25 mcg. daily. For geriatric patients or children, it is 5 mcg. daily. The manufacturer warns that it should be used with caution in the presence of angina pectoris, cardiac disease, ischemic states, or adrenal insufficiency.

Cytomel is available in 5 mcg. and 25 mcg. tablets in bottles of 100.

New Iron Complex

Ferronord (brand of glycamine iron) a new 'ion-protected" complex of ferrous iron and an amino acid for treatment of hypochromic anemias, is a product of Nordmark Pharmaceutical Laboratories.

It is recommended by the manufacturer for the common iron-deficiency anemias, hypochromic anemias of childhood and adolescence, "idiopathic" anemia in adult women, and hypochromic anemia in pregnancy or following acute or chronic blood loss.

Between-meal administration is recommended for optimal results. Average adult dosage, initially, is two tablets twice daily.

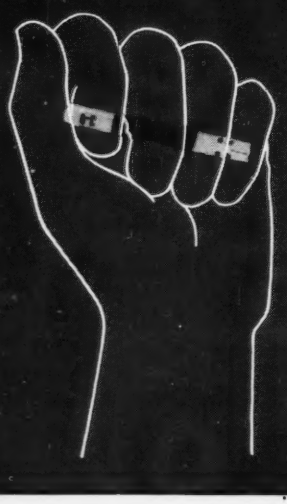
Tablets are supplied in bottles of 100. Each tablet supplies 40 mg. of ferrous iron.

NEW

Saves time
Simplifies O.R. procedure

Actual Size

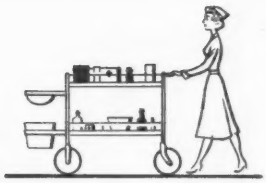
DEKNATEL
dry sterile
READI-WOUND
LIGATURE REELS



- Size is clearly marked *on reel.*
- Length of reel insures *proper fit in hand.*
- No need for holders of any kind.
- Eliminates whiplashing, tangling.
- Reduces O.R. handling to minimum. Merely open sterile tube and ligature is ready to use.
- Dependable Deknatel Surgical Silk and Cotton. Five yards per reel, 3 dozen reels in jar or can, *dry sterile.*

Samples submitted upon request.

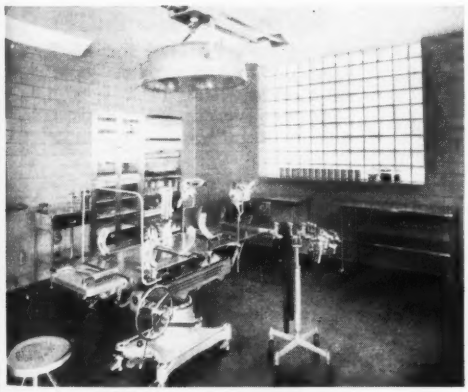
J. A. DEKNATEL & SON, INC.
QUEENS VILLAGE 29, NEW YORK



FOR BETTER PATIENT CARE

replace your obsolete items with durable stainless steel equipment

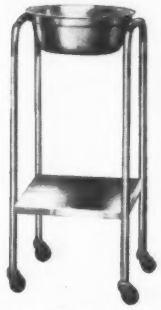
• Availability of Ford Foundation funds now offers many hospitals an opportunity for increased community service. An important step in that direction is the replacement of old and obsolete items with modern stainless steel equipment. This will result in increased working efficiency, reduced maintenance cost and a high degree of sanitation. Many hospitals have found that Blickman-Built equipment represents a sound investment in terms of durability and trouble-free service. Consult us if you have any equipment problems in your hospital.



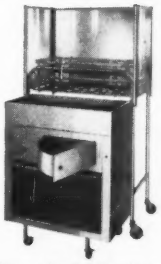
EXPLOSION HAZARDS are minimized in the major operating room of Mt. Sinai Hospital, Hartford, Conn., by the use of Blickman-Built stainless steel equipment fitted with electrically-conductive casters or tips.

Manhattan Mayo Instrument Stand

Clifton Revolving Stool

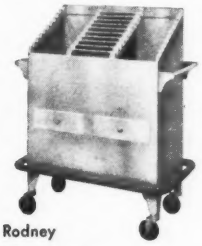


Baker Solution Stand

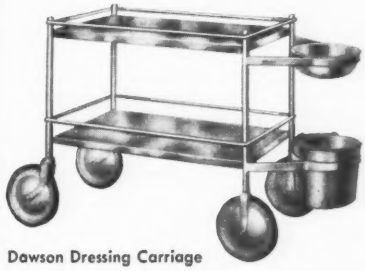


Mercy Model Bassinet

Howard Instrument Table



Rodney Chart Carrier



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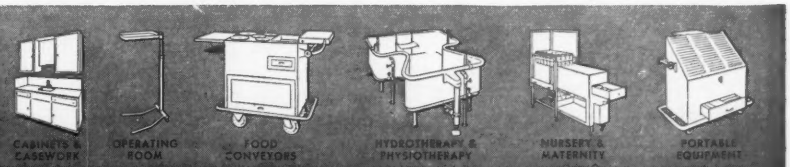

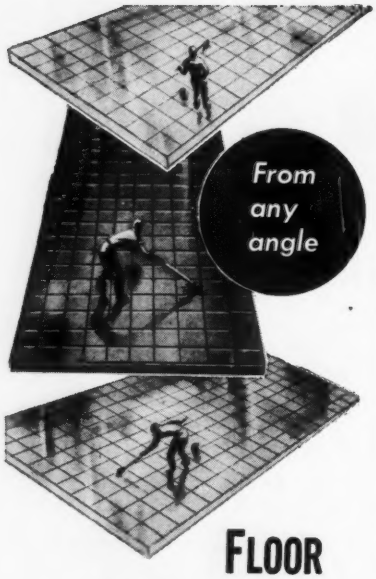

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Blood Bank Association Elects Officers

The American Association of Blood Banks, which met jointly with the Sixth Congress of the International Society of Blood Transfusion, September 3-5, in Boston, elected E. E. Muirhead, M.D. as president.

Dr. Muirhead is professor and chairman, department of pathology, University of Texas Southwestern Medical School, Dallas. He succeeded James J. Griffitts, M.D.

Other newly elected officers are: president-elect, Oscar B. Hunter Jr., M.D., Washington, D.C.; vice-president, Morton Grove - Rasmussen, M.D., Boston; treasurer, Mrs. Bernice Hemphill, San Francisco (re-elected). Marjorie Saunders, Dallas, Tex., is executive secretary.

Karl Landsteiner awards were presented by the association to Philip Levine, M.D., Raritan, N. J., and Alexander S. Weiner, M.D., Brooklyn, for outstanding contributions to the field of blood banking.

Given for the first time this year by the association was the John Elliott award for an outstanding piece of original investigation. Recipient was J. Garrott Allen, M.D., Chicago.

FTC Investigates Prices Of "Wonder Drugs"

Eighteen principal manufacturers of antibiotics have been sent questionnaires by the Federal Trade Commission in its effort to discover why "wonder drugs" cost so much.

Basic facts are requested on production, sales, patents, and other data relating to supplies and prices.

Overfeeding May Be Plaguing World

Overfeeding may affect the health of the world more than starvation, Paul Dudley White, M.D., Boston, told the second European congress of cardiology in Stockholm, Sweden.

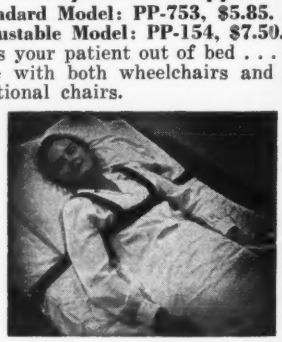
There has been an almost epidemic increase of coronary heart disease among leading citizens of all nations, Dr. White said.

Overnutrition, if found to be an important factor in the increase of coronary heart disease, may play an even greater role in the destiny of the world than undernutrition, he declared. He pointed out that where prosperity has reached even the common man, the laborer, the forester, coronary heart disease has followed along too.

For Patient Protection

Posey Vest Restraint
Provides a safe and simple means for keeping patient in bed with freedom to sit or stand up if desired. Shoulder straps to head of bed hold securely when required. Cat. No. P-555, $6.50 each in infant, med., small and large sizes. Also adult sizes: Cat. No. P-555A, $12.75 each. Satisfaction guaranteed. Send order today.

Posey Patient Support
Standard Model: PP-753, $5.85. Adjustable Model: PP-154, $7.50. Gets your patient out of bed . . . useable with both wheelchairs and conventional chairs.



McDonald Restraint
Standard Model: P-4147, $5.75. Extra-heavy model: P-353. Riveted construction with keylock buckles, $18.75 each. Keeps patient in bed.

SEND YOUR ORDER TODAY
And Write for Illustrated Literature About Other Posey Hospital Equipment

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(Continued from page 7)

Isotopes Determine Inroads of Disease

Injection of isotopes into the blood stream makes possible the rapid, accurate evaluation of inroads made by acute and chronic illnesses, such as cancer and heart disease in patients being considered for surgery, Francis D. Moore, M.D., Harvard Medical School, reported at a recent military medico-dental symposium in Boston.

The isotopes are used to map the degree of imbalance in certain areas of body chemistry, Dr. Moore said. The degree of chemical imbalance, he explained, denotes the progress that disease has gained in the body. "Cancer depletes and starves tissues as the body fights to maintain a balance in metabolism," he pointed out. "The extent of this imbalance can be measured by comparison of body compositions and chemicals with normal levels."

One injection is given of the diluted radioisotopes, sodium (NA^{24}), potassium (K^{42}), bromine ($Br^{82}r$), and chromium (Cr^{51}), in combination with a nonradioactive isotope, deuterium (heavy water). From this injection, measurement may be made of total red-blood cell volume; total volumes of chlorine, potassium, sodium and water; total plasma-cell volume in the blood and the amount of extracellular water present in the body.

The isotope dilution process developed by Dr. Moore and his associates is based on the relation of known volume to unknown volume. Dr. Moore explains the measurements in this way:

"We might imagine a pail full of gray bird shot, the number of which is unknown. If we add to that pail, a known number of bird shot painted red and mix them evenly throughout the pail, we can then take out a fair sample and by the number of gray shot found with each red shot we calculate the total number of gray shot in the pail by our same dilution formula.

"In the case of potassium, for example, we inject radioactive potassium, let it mix with the body potassium, and then measure its concentration. From this we can determine the total volume of body potassium. The same holds true for sodium, bromine, chromium, and nonradioactive deuterium."

There is no danger to the patient from overexposure to radioactivity, because the total radiation is very small and short-lived, he said.

Special Care Unit For Seriously Ill

A plan for segregating all critically ill surgical patients in a single hospital area staffed by trained nurses was outlined in the Oct. 6 issue, *Journal of the American Medical Association.*

The pressure for graduate nurses in other areas in the hospital is relieved by putting all critically ill patients together, according to J. Murray Beardsley, M.D., J. Robert Bowen, M.D., and Carmine J. Capalbo, M.D., Rhode Island Hospital, Providence.

Additional nurse's aides and practical nurses can be used in other parts of the hospital.

Weed Killer 100% Effective Against Poison Ivy

A new chemical weed killer, developed by the American Chemical Plant Co., Ambler, Pa., is being used to attack a record crop of poison ivy in Valley Forge Park, Pa.

Robert H. Beatty, agricultural research director of the firm, says tests showed the chemical, weedazol, to be 100 percent effective against poison ivy. A comparatively rare chemical called amino triazole, chief use for which originally was in the manufacture of camera film, is the effective agent.

HEPATITIS*...in your office?

It has been estimated that up to 6 per cent of the population may be carriers of virus B (serum hepatitis).†

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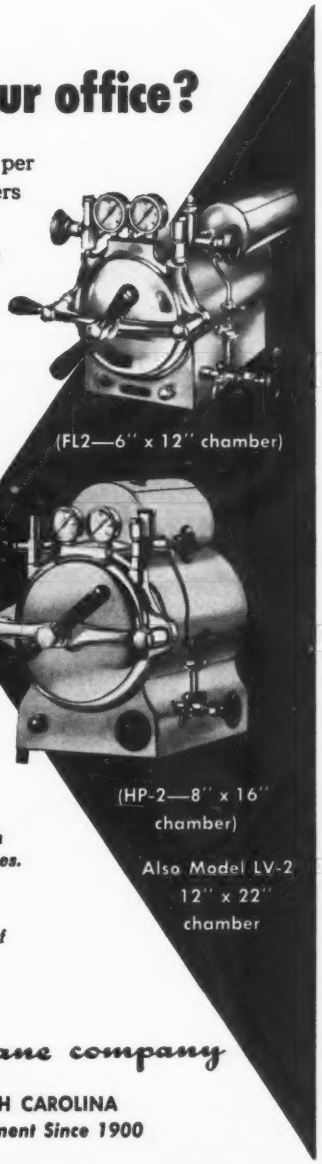
Be Safe—Be Sure

AUTOCLAVE

Only in an autoclave can you achieve complete sterilization of unwrapped instruments in 3 minutes at 270°F (27 lbs.) or 10 minutes at 250°F (15 lbs.).

These high speed Pelton models are self-contained and easy to operate, assuring certain destruction of bacteria. Instruments, gloves, fabrics and solutions can be accommodated with complete safety. Call or write today for literature on Pelton autoclaves.



(FL2—6" x 12" chamber)

(HP-2—8" x 16" chamber)

Also Model LV-2 12" x 22" chamber

*Now in 2nd place on U. S. Public Health Service List of Selected Notifiable Diseases.

†"The Management of Viral Hepatitis," by Hyman J. Zimmerman, M. D., Journal of American Academy of General Practice, June 1955

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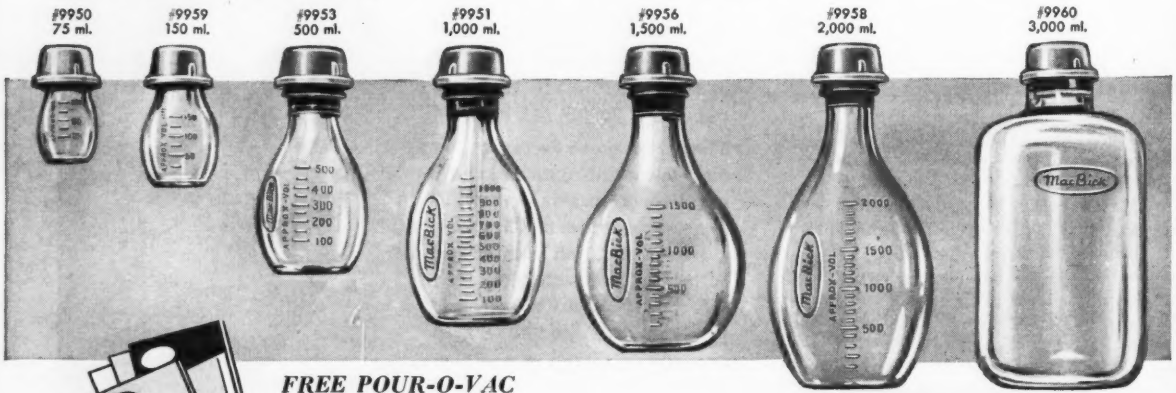
POUR-O-VAC®

flasks are available in *seven sizes*, from 75 ml to 3,000 ml capacity. There is a size to fulfill every need for surgical, obstetrical, urological fluid container/dispensers.

- Miniature Pour-O-Vac flasks *(75 and 150 ml)* and closures are used for small amounts of sterile fluids such as Procaine, Normal Saline and distilled water for mixture with dry medications and dispensing of small quantities of sterile fluids.
- *500 ml* capacity: popular for individualized sterile saline in post natal perineal care and in the O.R.
- *1,000 ml* receives considerable use in the O.R. because of its substantial capacity, light weight and ease of handling due to its tapered neck and perfect balance.
- *1,500 ml* offers increased capacity, yet the pear shape still permits ease in handling.
- *2,000 ml* answers the demand for large capacity containers in the Delivery Room and Cystoscopy work.
- *3,000 ml*, cylindrical in shape, designed for bulk storage of irrigating fluids and features space saving in the autoclave and storage shelving. Used for initial filling of solutions bowls in the O.R., the 3,000 ml flasks greatly reduce preparation time as well as capital investment in flasks. And many are finding this the ideal flask for T.U.R. work.

Enjoy added safety, convenience, economy in the storage and use of *truly sterile* surgical fluids. Self-sealing closure permits re-seal of partially used fluids; maintenance of sterility may be confirmed by testing with water hammer click.



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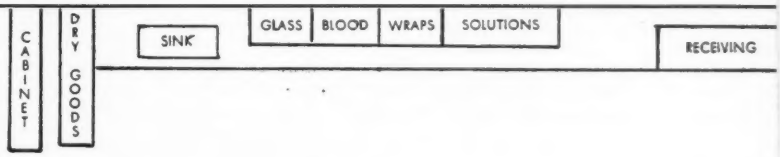
Central Supply

a section of special interest to

Central Supply Room Staff

contributions are welcome



Newly Organized Central Service Improves Efficiency, Saves Money

By Brother Dominic, C.F.A.*

• In the hospital of today, central service has emerged as an independent factor in the maintenance and improvement of patient care. As administrators have realized the assistance central service can give to the nursing units, the emphasis on its utility has increased.

Alexian Brothers Hospital had previously had a central supply department which performed limited functions. In it were kept needles, syringes, oxygen tents, Wangensteen suction equipment, and thermometers. Only needles and syringes were sterilized in the department.

The administrative committees and the division of nursing services, after serious consideration, decided that a central service unit was needed.

The new department has now been in operation for over two months. The initial outlay of capital necessary for the establishment of the department will soon be offset by the saving in material, by the reduction of losses resulting from carelessness of employees in handling equipment, and by the removal from the surgical team of the burden of assembling and sterilizing linen and instrument packs, and conditioning and sterilizing gloves.

With the establishment of a central service department, a cost analysis is of prime concern to administrators. Generally, the cost can be divided into two main categories, direct and indirect. Direct cost is concerned with such items as the number of personnel requisite for maintaining the department, personnel wages, and the cost of supplies. Indirect cost includes such items as necessary equipment, linen expenses, housekeeping expenses, and the expenses needed for the general household property.

Because it is the duty of the administration to regulate and guide the various expenditures of central service, the data should be broken down specifically into expendable and nonexpendable items. Expendable items then are broken down according to the manner in which they are used—for instance, those used in direct patient care and those used in preparing the necessities for such care, e.g., linen, gloves, powder, tape, steam, and electricity.

After we decided to establish a central service department, the administration committee evaluated proposed floor plans, nursing procedures, and utilization of material within the department. When a change in procedures involved major medical problems, or when standardization was necessary, the suggested changes were referred to the surgical committee of the medical staff for consideration and evaluation.

The nursing procedures were reviewed and passed by the administrative committee, and approved by nursing service. Since administration and nursing service work in such close harmony, few problems were encountered along these lines.

In some instances, minor changes, made previously, eliminated many of the unnecessary equipment and supplies that served no purpose.

Before the establishment of the department, there was a noted loss of equipment each month. To begin with, each movable item of equipment was numbered by the department and a record kept of the equipment and which division claimed it. Carelessness, breakage, and theft have decreased, with the result that many dollars have been saved for the institution each week.

The physical setup of the previous supply department was inadequate. As the accompanying drawing shows, at the present time soiled materials are received in one area and the dispensing of sterile and clean equipment is in another area.

In the revision and standardization of the department, central service was asked to pack and sterilize daily necessary linens for surgery, instrument packs, and drums from the various dressing rooms and emergency room area.

A perpetual inventory was set up. All equipment stored in various areas of the hospital was moved to the central area. All forms used within the hospital have been centralized within the central service department. This we feel is rather unique. It often happens that the purchasing agent is confronted by departmental heads with requi-

(Continued on next page)

*Assistant administrator, Alexian Brothers Hospital, Chicago.

sitions for various forms when the supply is extremely low. With centralization of all these forms, the central service supervisor can easily determine when a supply is running low, and an order can be placed at the proper time.

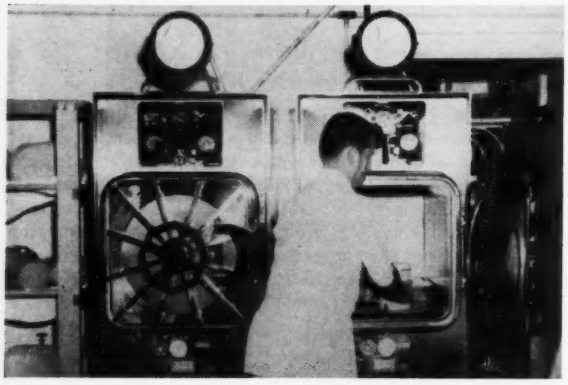
Oxygen equipment is stored in the department, as it was before. A minimal amount of oxygen is stored there —not exceeding the city code. Keeping oxygen in central service saves time for the personnel in the department, inasmuch as unnecessary trips are not made to the central storage area for oxygen.

DEPARTMENT STAFF

Additional personnel in the new area were necessary. The following schedule was drawn up to assure adequate coverage over the 16-hour period the department is open:

From 7 a.m. to 12 noon and from 3 p.m. to 6 p.m. are hours for the supervisor.

An attendant is on duty from 7 a.m. to 3:30 p.m.; from



9 a.m. to 5:50 p.m., and from 2:30 to 11 p.m.

After 11 p.m., the night supervisor utilizes the central service department as his office. If equipment is needed, he dispenses it to the various nursing units.

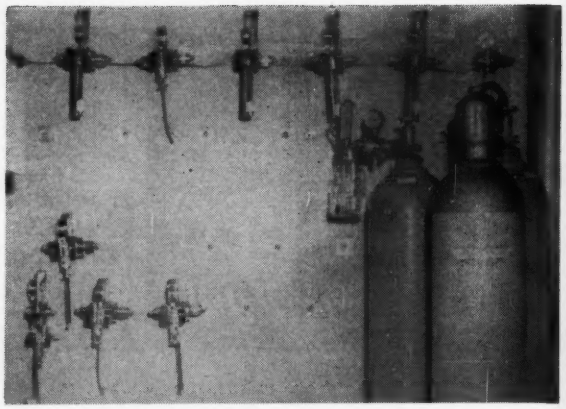
A pickup and delivery service has been instituted from 8 a.m. to 3 p.m. Any equipment needed outside of this period must be requisitioned by the floors. A Kardex gives the exact location of equipment within the central service department.

The re-evaluation of the department will never end. Continuous study is necessary in the standardization of supplies, procedures, and labeling of items.

In the establishment of the central service department, consideration should be given to present-day methods of doing a job, and more complete centralization. Items of primary concern will lead to space allocation, more complete centralization of functions, and location of the central service work and storage area. The subjects which should be considered are:

(1) Flow of work
(2) Simplification of procedures
(3) Standardization of procedures.

Once the job has been outlined and established, the most economical way must be found for performing the operation. This can be accomplished by a time and motion study. Careful evaluation should be made of each situation. An attempt should definitely be made to eliminate unnecessary movements, to combine operations, and to arrange the sequence to improve the work pattern and simplify the necessary operations.



Shown above is a section of the mantel on wall where oxygen regulators are hung. Keeping a minimal amount of oxygen in central service saves personnel trips to the central storage area.

Left: Mr. Dawson, central supply attendant, loads one of two fully automatic sterilizers. Since reorganization, the central supply unit now packs and sterilizes necessary linens for surgery every day, as well as instrument packs and drums from dressing rooms and emergency room area.

Tools and materials should be processed and located in an area convenient and easily accessible to the person assigned to perform the procedure. Carts should be provided to deliver materials to the necessary area.

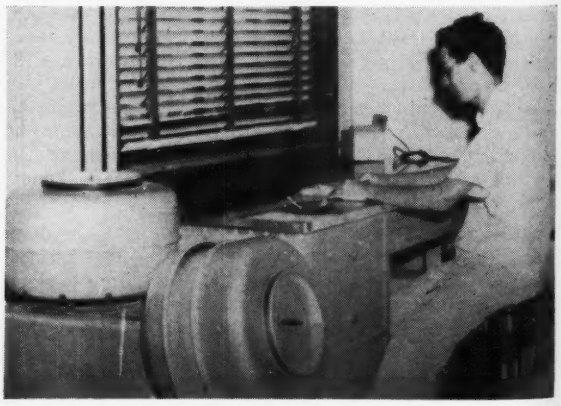
Our central service department is on the third floor, which is in the center of the hospital. Since the presently allocated area does not permit further extension of the department, the space devoted to activity is divided into three rooms. The special subdivisions are:

(1) Glove-cleaning and testing area
(2) Supervisor's area
(3) Glove-conditioning area, with the work area for assembling of glove packs
(4) Linen storage area, with the necessary tables for making packs
(5) Oxygen area
(6) IV fluid storage area.

The necessary equipment is stored in close proximity to the appropriate area.

Clean equipment and sterile equipment had been divided

(Continued on page 118)



Above: Mr. Fletcher, central supply attendant, is shown working at the glove-conditioner in central supply unit.

AN IMPORTANT ADVANCE *in Controlled Analgesia*

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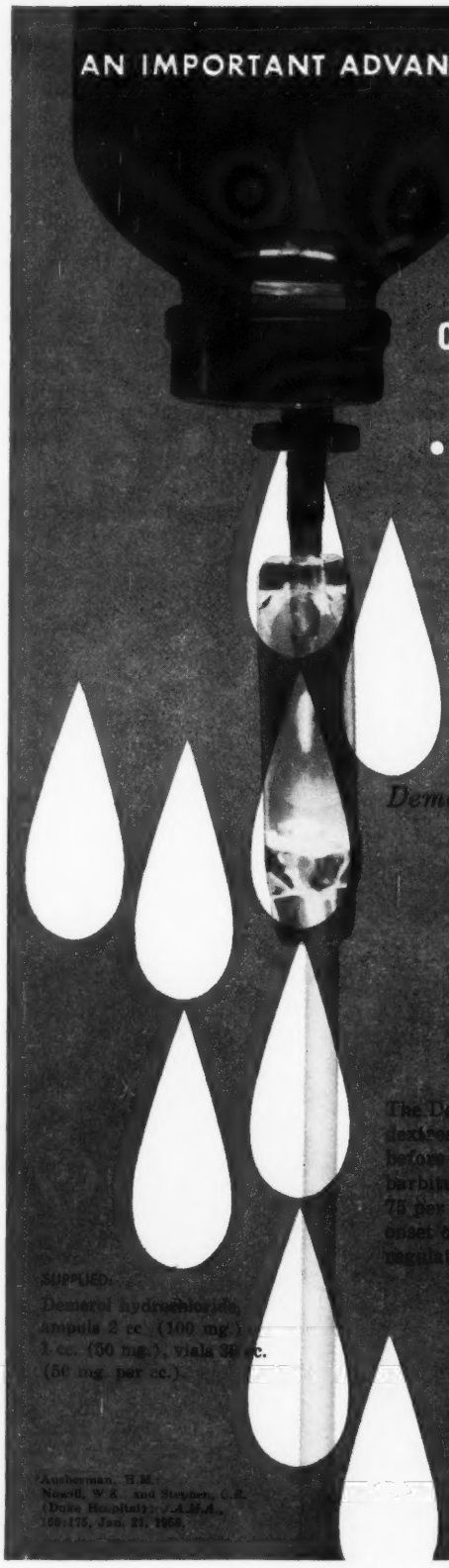
hydrochloride

continuous I. V. DRIP

(0.5 mg./cc.)



- *smooth* INDUCTION
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- *smooth* RECOVERY

Given in combination with an ultra short-acting barbiturate and nitrous oxide-oxygen, Demerol drip assures smoother anesthesia, potent easily controllable analgesia, as well as more rapid and more pleasant recovery.*

Demerol drip, in a study of 1000 patients, has shown these advantages:*

- 31 per cent less short-acting barbiturate required than in controls
- reflex irritability diminished
- minimal interference with cardiac and respiratory functions
- smooth, rapid induction and recovery

The Demerol hydrochloride drip (250 mg. in 500 cc. dextrose 5 per cent in water or normal saline) is started before anesthesia is induced by the short-acting barbiturate (2 to 2.5 per cent solution). Nitrous oxide 75 per cent and oxygen 25 per cent is given after onset of unconsciousness; the amount of Demerol is regulated by respiratory rate, surgical stimuli.

SUPPLIED:
Demerol hydrochloride,
Ampuls 2 cc. (100 mg.)
1 cc. (50 mg.), vials 30 cc.
(50 mg. per cc.)

Write for leaflet "Demerol hydrochloride, Intravenous Use" which discusses clinical experience, technics, precautions, etc.

Winthrop LABORATORIES NEW YORK 18, N. Y.

*Ausherman, H. M.
Nowell, W. E. and Steyben, C. E.
(Duke Hospital): J.A.M.A.,
160:175, Jan. 21, 1956.

Demerol (brand of meperidine). Trademark reg. U.S. Pat. Off.

(Continued from page 116)

into two areas in the sterilizing room.

The necessary forms for current use on nursing divisions are stored near dispensing areas in small quantities adequate for the departments.

NEED TO PLAN STORAGE

Poor storage and distribution can be factors in the loss of motion and time. It is important to plan any storage and distribution system to make space available when needed.

An analysis has been made by the hospital of the various items used on the nursing stations and the frequency of their use. As a result, the items frequently used are located in easily accessible areas, and those needed less frequently are farther from the dispensing areas.

The quantity that is stored has been determined by a use analysis, drawn up on the needs for a 24-hour period. This system has reduced the time spent by the nursing personnel and doctors in waiting for fluid or general procedure trays. Additional intravenous fluids are stocked in the storage area directly adjacent to the present central service area.

SUPERVISOR'S QUALIFICATIONS

The supervisor must be a person of decision and leadership, with the ability to evaluate and analyze jobs and to supervise tasks. He must have a knowledge and understanding of the needs which are to be met by the department and the functions of the staff in relation to these needs.

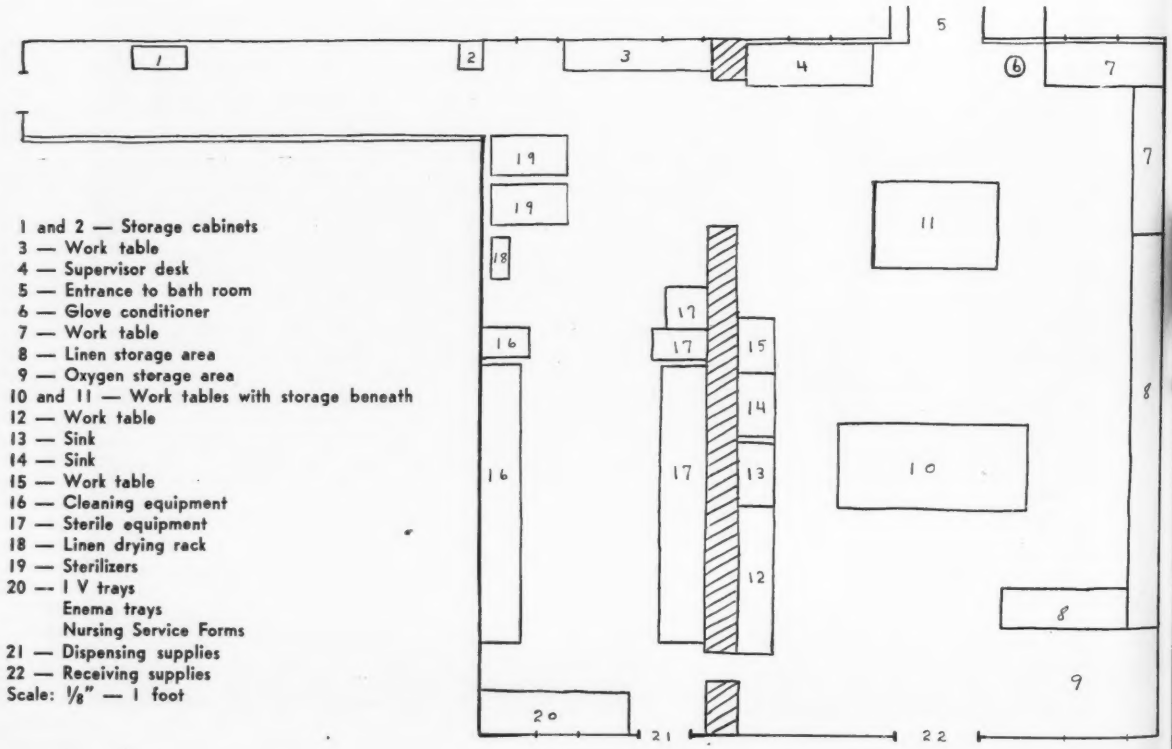
There is a constant need for teaching new methods, of cleaning, of preparing supplies, of operating the sterilizers, of assembling equipment, and of preparing general procedure trays. The supervisor skilled in work simplification and job assignment will eliminate many administrative problems. Every operation has three parts: preparation, assembly, and storage. The supervisor analyzes each step to achieve a method to complete the work safely and accurately.

Under our reorganization plan, the department has been equipped with many labor-saving devices, such as glove conditioner, a needle-sharpener, and two large automatic American Sterilizer autoclaves.

The interest of the department personnel has resulted in the effectiveness of the central service area. We have made a study of new methods in order to improve interdepartmental relations. Without the cooperation of department personnel and the nursing service areas, it would have been difficult to establish a program with such good interdepartmental relations.

The primary function of the central service department is to supply the nursing divisions and the departments throughout the institution with the type of supplies to effect better patient care. Although the department is relatively new and administrative problems have arisen, we feel that in due time many of these problems will be eliminated, and the service given by this department will be fully realized and appreciated.

Central Service Floor Plan


1 and 2 — Storage cabinets
3 — Work table
4 — Supervisor desk
5 — Entrance to bath room
6 — Glove conditioner
7 — Work table
8 — Linen storage area
9 — Oxygen storage area
10 and 11 — Work tables with storage beneath
12 — Work table
13 — Sink
14 — Sink
15 — Work table
16 — Cleaning equipment
17 — Sterile equipment
18 — Linen drying rack
19 — Sterilizers
20 — I V trays
Enema trays
Nursing Service Forms
21 — Dispensing supplies
22 — Receiving supplies
Scale: 1/8" — 1 foot

ON THE
"DISTURBED"
WARDS...

ARRESTED TURBULENCE

SPARINE quiets and relaxes the acutely agitated patient without clouding his perception or inducing disabling lethargy. Disturbed, combative patients become calm, are able to converse rationally, to care for their own needs, and to participate in supervised group activity. SPARINE thus transforms the acute ward from a place of bedlam to a reasonably quiet, orderly service. In this atmosphere, the greatest benefit from psychotherapeutic measures can be expected.†

INDICATIONS:

• **The acute psychotic** • **The drug addict** • **The acute alcoholic**

For rapid initial control, *intravenous* administration. For maintained control, *oral* or *intramuscular* administration. Injection pain is minimal, and necrosis at the injection site has not been reported.

†References on request

NEW Potent Ataractic Drug

Sparine*

Promazine Hydrochloride

10-(γ-dimethylamino-*n*-propyl)-phenothiazine hydrochloride

Hydrochloride

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Philadelphia 1, Pa.

For the entire patient population

a new antimicrobial spectrum

that includes "resistant" staphylococci

Synergistically strengthened multi-spectrum antibiotic formulation providing:

1 a new maximum in therapeutic effectiveness

2 a new maximum in protection against resistance

3 a new maximum in safety and toleration

superior control of infectious disease through superior control of the changing microbial population

Available in 250 mg. capsules (83 mg. oleandomycin, 167 mg. tetracycline). Bottles of 16 and 100.

mamycin*

OLEANDOMYCIN TETRACYCLINE

NEW therapeutic control when "resistant" *Staphylococcus* is known to be the causative agent

Matromycin®

BRAND OF OLEANDOMYCIN

A new antibiotic agent which combats resistant staphylococci and helps control superinfection with these strains, particularly among hospitalized patients where the causative agent can be determined. *Available in 250 mg. capsules. Bottles of 16.*

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clinical notes

Reports Good Results With Artificial Kidney

The artificial kidney is an important aid in the conservative management of selected patients with acute renal failure, Lukemeyer *et al.* report in *J. Indiana M. A.* 49:647-654, 1956.

Of 59 candidates for hemodialysis since the artificial kidney has been available, 19 have had a total of 25 dialyses, they point out. Thirteen had one, and six received two.

Thirty-two of the 59 had acute renal insufficiency, and varied in age, severity of disease, and precipitating factors for the kidney shutdown. Of this group, 10 of the most seriously ill were subjected to hemodialysis. Six died, and four eventually recovered.

Of four patients with chronic renal disease treated with hemodialysis, all eventually succumbed.

A girl of 19 attempted to commit suicide by taking 100 of 60 mg. tablets of phenobarbital. With a six-hour dialysis, 4.04 gm. of phenobarbital was recovered. The girl made a complete recovery.

Facial Tissue Sensitization

Facial tissues impregnated with synthetic resins, such as the urea-formaldehyde resins, are capable of sensitization, according to Peck and Palitz, writing in the *J.A.M.A.* 160: 1226-27.

In a study of 50 subjects (15 males and 35 females), a sensitivity reaction occurred in three (six percent), the authors report. In no case was there reaction when the tissue used was free of chemical additives.

Treatment with BZ-55

In 22 diabetics treated with BZ-55, very good results were noticed in patients with mild disease, Di Lorenzo and Miola report in *Riforma med.* 70:619-623 (June 2), 1956.

Patients were from 42 to 72 years of age. Only four were below 45. Insulin was withdrawn in 12 patients and satisfactorily replaced with BZ-55. The drug had no effect on the weight of the patients.

BZ-55 had no effect in a woman with a severe form of diabetes. The treatment lowered the blood-sugar level and the diabetic hyperlipemia.

Dosage was 2.5 gm. the first day, 1.5 gm. for the next 10 days, and 1 or 0.5 gm., depending on the patient, for the remaining days of treatment. Return to normal glycemia was noticed after 48 hours in some patients and after 6-10 days in others. BZ-55 was given after meals. There were no side-effects.

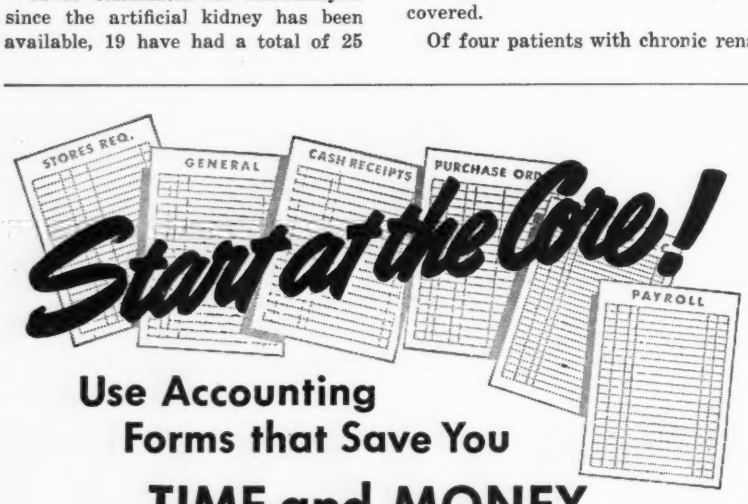
Reactions to Meprobamate

Adverse reactions seen after the administration of the tranquilizing drug meprobamate included cutaneous, muscular, gastrointestinal, and paradoxical cerebral effects, according to Friedman and Marmelzat, writing in *J.A.M.A.* 162: 628-30 (October 13, 1956).

The cutaneous effects, seen in five cases, were chiefly purpuric and were accompanied by intense itching. One 400-mg. tablet of meprobamate sufficed to produce the skin lesions without previous exposure.

Temporary palsy of extraocular muscles produced diplopia in one case. Severe diarrhea occurred in another. Paradoxical cerebral reactions in the form of extreme excitement were seen in three cases.

The seven patients described by the authors recovered after the drug was withdrawn.



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College and Hospital Unites For Nursing Course

Under an agreement designed to help meet the acute shortage of graduate nurses, students of the nursing sciences division, Queens College of the City of New York, will now receive their clinical training at The Long Island Jewish Hospital.

This is believed to be the first such arrangement between a wholly municipally-owned college and a voluntary hospital.

With approval of the New York State Board of Regents and the city's Board of Higher Education, the training course will be two years, instead of the minimum of three years previously required to qualify for graduate R. N. examinations.

The course is experimental to determine whether an intensified training program can produce qualified graduate nurses in two years.

Coronary Heart Death Rates Vary Widely in U.S.

Wide variations in death rates from coronary heart disease are reported in different parts of the U. S. by the Public Health Service, with rates twice as high in some states as in others.

According to officials, this survey is a step toward a nationwide study of variations in the incidence of heart disease.

The survey, reported in the September 20 issue of *Public Health Reports*, showed that coronary heart disease causes about a third of all deaths among white males in the age group 45 to 74, and about a fifth among men 35 to 44.

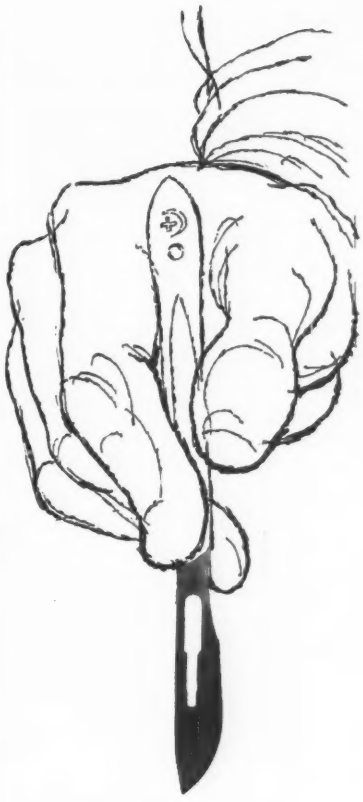
Lowest death rate for coronary heart disease among white males of all ages in 1950 was in New Mexico, 191.1 per 100,000 population. Arkansas and Kentucky had the next lowest rates.

Rates for white males were highest in New York (393.8), Rhode Island (364.3), and the District of Columbia (344.3).

Variations in death rates from coronary heart disease among white females were even greater—83.4 in New Mexico as compared with 217.4 in New York.

Polio Foundation Appoints Medical Director

Thomas M. Rivers, M.D., New York City, has been appointed medical director, National Foundation for Infantile Paralysis, succeeding Hart E. Van Riper, M.D., who left October 31 to become medical director of Geigy Pharmaceuticals, Ardsley, N. Y.



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